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ABSTRACT

These 11 papers begin by discussing the delivery of mental health services to non-urban black consumers, focusing on traditional education for practice, ethnocultural sensitivity, and geography and victimization. The expanding clinical social work roles in nontraditional approaches to rural aging are discussed also, and mental health, social work practice, and a case example are presented. Alternative care interventions in rural mental health centers are explored, and a pilot study on minority women and depression is provided, including information on incidence and treatment. The paper on cross cultural conflicts between urban service providers and rural clients discusses labeling, interaction orientations, definitions of time, approaches to problem solving, interpretations of change, and the role of the sacred among significant others. Studies on admission patterns of blacks in mental health centers and on the influence of rural social networks on the perception and utilization of mental health services are presented. Results of a survey of eight programs set up in North Carolina counties following a class action lawsuit in 1979, ("Willie M" programs), are described including population, services, utilization of services, and conclusions. An outreach approach to rural mental health practice is described, and services to rural African Americans are discussed in relation to variables influencing underutilization, help giving systems, and outreach strategies. The proceedings conclude with scenes from therapy with an Appalachian family, including goals, family characteristics, and intervention strategies. All papers include references. (BL)

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Conference Proceedings

RURAL MENTAL HEALTH IN NORTH CAROLINA

SOCIAL WORK PRACTICE AND ETHNOCULTURAL ISSUES

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Mental Health Specialization
School of Social Work
The University of North Carolina at Chapel Hill

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Conference Proceedings

RURAL MENTAL HEALTH IN NORTH CAROLINA
Social Work Practice and Ethnocultural Issues

May 20, 1983

Sponsors

The Mental Health Specialization
Peter Johnson, Ph.D.
William Saur, Ph.D.
Sarah Smith, M.S.S.
Rachel Dedmon, Ph.D. - chair

The School of Social Work
The University of North Carolina at Chapel Hill
Chapel Hill, North Carolina

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The Mental Health Specialization
The School of Social Work
The University of North Carolina at Chapel Hill

RURAL MENTAL HEALTH IN NORTH CAROLINA
Social Work Practice and Ethnocultural Issues

May 20, 1983
Greenlaw Building -- Carolina Campus

8:00-9:00 A.M. -- Registration, Coffee and Doughnuts

9:00-10:45 -- Opening Session -- *Dr. Rachel Dedmon*, Convenor*
Room 101 *Dr. Peter Johnson*, Moderator*

Welcome -- *Dr. John Turner, Dean*
Mr. Don Willis, State Division of Mental Health, Mental Retardation and Substance Abuse Services

Address -- *Dr. Arthur Cox, Director of the Division of Social Work and Community Services, Southern Illinois University*

"Delivery of Community Mental Health Services to Non-Urban Black Consumers: A Case for Advanced Generalist Practice"

Responses by: *Ms. Mary Cannady, M.S.W., Vance County Mental Health Center (retired)*
Ms. Polly Penland, M.S.W., Western Carolina University

11:00-12:30 -- Morning Workshops

1. Expanding Clinical Social Work Roles: Non-Traditional Approach to Aging -- *Joann H. Haggarty, M.S.W., Orange-Chatham Comprehensive Health Center.* ROOM 103 *Moderator: Gary Nelson, D.S.W.*

2. Alternative Interventions in a Rural Mental Health Center -- *Erica S. Rothman, M.S.W., Mary Cleary, M.S.P.H., and Karen Creasman, M.S.W., Chatham County Mental Health Center.* ROOM 106
Moderator: Ruth Boorman, M.S.W.

3. Minority Women and Depression -- *Virginia Bristol, M.S.W., Vance County Mental Health Center.* ROOM 221
Moderator: Elaine Barney, M.S.W. student

4. Cultural Conflicts Between the "Urban" Professional and the Rural Clients and Staff -- *Thomas Plaut, Ph.D., Mars Hill College.*
ROOM 104 *Moderator: Virginia Wittekind, M.S.W.*

5. Admission Patterns of Non-Whites in Free Standing Mental Health Centers and Comprehensive Health and Mental Health Centers -- *Glenda Harris, M.S.W., Orange-Person-Chatham Mental Health Center.*
ROOM 107 *Moderator: Hortense McClinton, M.S.W.*

12:30-2:00 P.M. -- Lunch on Your Own

2:00-3:30 -- Afternoon Workshops

6. The Influence of Rural Social Networks Upon the Perception and Utilization of Community Mental Health Services -- *Walter F. LaMendola, Ph.D., East Carolina University and Melodie Thomas, M.S., Pitt County Mental Health Center.* ROOM 221 *Moderator: Leslie Stone, M.S.W.*

7. Service Survey of Eight Willie M Programs -- *Trish Rafalow, M.S.W., and Susan Scully, M.S.W., Orange County Mental Health Center.* ROOM 103 *Moderator: Mary Sue Cherney, M.S.W. Student*

8. Outreach Approach to Rural Area Mental Health Practice -- *Robin Hamilton, M.S.W., and Sue Wheeler, M.S.W., Johnston County Mental Health Center.* ROOM 106 *Moderator: Mark Bailes, M.S.W. Student.*

9. Reaching Out to Rural African Americans: An Underserved Population -- *Salimah Majeed, M.S.W., and Iris Carlton-LaNey, Ph.D., The University of North Carolina at Charlotte.* ROOM 107 *Moderator: Audreye E. Johnson, Ph.D.*

10. Scenes from an Appalachian Family -- *Jim Anderson, M.S.W., Mountain Youth Services.* ROOM 104 *Moderator: Barbara Petrou, M.S.W.*

3:30-3:45 -- Break, Soft Drinks

3:45-4:45 -- Panel -- *Dr. William Saur*, Moderator*

"North Carolina's Response to Ethnocultural Needs in Rural Mental Health. What is it, what should it be?"

Practice -- *Mr. Butch Sanders, M.S.W. Cherokee Indian Hospital*

Education -- *Ms. Sarah Smith*, M.S.S. UNC-CH School of Social Work*

Government -- *Mr. Don Willis, State Division of Mental Health, Mental Retardation, and Substance Abuse Services*

Adjournment

**Mental Health Specialization Faculty*

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Delivery of Community Mental Health Services to Non-Urban Black Consumers: A Case for Advanced-Generalist Practice

Arthur J. Cox, Ph.D.
Southern Illinois University
Carbondale, Illinois

Provision of appropriate and adequate mental health services to black consumers has continually posed a dilemma to the traditional mental health system. One indicator of this is an apparent dual system of care. One system appears to be for those who are able to pay and live in close proximity to mental health facilities; they receive care from highly trained professionals. The other system is for those who are poor and live in semi-urban and non-urban areas. These consumers are more likely to receive institutional care. The former system tends to be for middle class consumers who are upwardly-mobile striving individuals and considered good treatment cases; the latter is for non-whites, the poor and consumers living in outlying areas of metropolitan or major cities. Major contributors to this apparent dual system of care are economic, geographic, and procedural inaccessibility.[1]

Economic inaccessibility reflects potential black consumers' lack of funds to purchase needed services or the lack of available means to secure needed mental health services through in-kind or vendor payments.

The majority of community based facilities are situated either adjacent to or connected with a general hospital or located in the developing fringes of a larger city. In the case of a multi-county area, the facility is located in the largest city. This situation is problematic because utilization patterns tend to reflect the concentric ring principle[2]; that is, the primary consumers being the closest to the facility. In the case of those facilities located in the developing fringes of a city, many blacks are denied access because of poor public transportation. They view facilities located in relatively more affluent areas as being for "them", and not for "us". Facilities connected to general hospitals are often accessible physically, but may be perceived as "fiscally" inaccessible.

Procedural issues tend to reflect the values, attitudes, and the misconceptions that mental health practitioners have about black consumers. These misconceptions, which are a combination of values and attitudes developed over time, influence the following processes: black client acceptance, diagnoses, type and length of treatment.

Since they are not generally seen as good treatment cases by mental health practitioners, black consumers tend not to be referred for treatment by professionals in community-based facilities. Instead, they tend to be diagnosed more severely than whites and offered less autonomous forms of treatment.[3] Consequently, blacks discontinue treatment sooner than whites, and the pattern of exiling blacks to state hospitals persists.[4] Regardless of whether or not intensive care is needed, state hospitals become the repository for blacks of both poor and moderate means from both urban and non-urban areas. This dual system of care perpetuates and intensifies such a pattern. The literature is filled with evidence that suggests a preselection process is operable, whether by design or otherwise, which limits the number of black consumers initially seen and those ultimately accepted

into treatment by the staff of community based facilities. Part of this process involves the practitioner's preference for potential consumers who are "good treatment cases". These persons are those who are young, motivated, introspective, and who have few reality differences.[5] Additionally, mental health professionals prefer students, suburban wives, upwardly-striving junior executives, and others with whom it is relatively easy for them to identify.[6] Few of these individuals tend to be black. Another part of this process involves the professional's preference for those consumers with problems which will sharpen skills in an area the mental health practitioner has selected to specialize. Again, these kinds of consumers typically are those identified above and few tend to be black.

What is more significant, however, is that education for practice in the mental health arena has not provided appropriate training to reshape values effectively, knowledge and skills necessary to begin to solve the present dilemma of providing adequate mental health services to black consumers.

The purpose of this presentation is to suggest a conceptual model for advanced generalist practice which will enhance the delivery of mental health services to black consumers in non-urban areas. It is my contention that community mental health services targeted for non-urban black consumers can best be delivered by social workers trained as comprehensive mental health service providers. This means social workers must have training which transcends methods, consists of ethnocultural sensitivity, and recognizes and accepts geography and its impact on potential mental health consumers. Before explicating the conceptual model for advanced generalist practice, these three distinct but mutually reinforcing factors need elaboration.

TRADITIONAL EDUCATION FOR PRACTICE

Traditional education for practice in the mental health arena has been divided into methods: casework, group work, community organization and sometimes policy, planning and administration. At other times, it is divided into micro, mezzo, and macro practice. This conceptual framework not only blurs the definition of practice, but also complicates the role integration necessary to engage blacks or any other human being in "healthy" and "helpful" relationships.

There are at least three attributes of current and past social work history which refutes the validity of this traditional description of training social workers for practice. This artificial division of practice suggests a unique body of knowledge, skills and techniques for each. This neglects common elements of practice germane to all methods and the variety of roles social workers must engage in to carry out their jobs effectively.

Early results of a random sample of social work job announcements taken from the St. Louis Post Dispatch, a study which was begun December 1982 and will conclude July 1983, show that practitioners must be equipped to use several practice modalities.[7] Only one of four job announcements specifies one method, and even when the advertisement specified one method, it tended to indirectly suggest others, for example:

SOCIAL WORKERS: The Presbyterian Home for Children, a residential center for adolescents, needs an EXPERIENCED Master's degreed social worker. Preference given to those with Positive Peer Culture experience.

The other three identified at least two, or at most three or more job functions which cut across traditional methods, for example:

SOCIAL WORKER DEVELOPMENTAL DISABILITIES: Major medical center seeking experienced & innovative social worker-/family therapist with knowledge of developmentally disabled children. Duties include performing family assessments as a team. Counseling parents, instruction of house staff and some research duties. Recruitments: Master's degree with 2 years experience, plus a knowledge of this special population. Competitive salary and fringe benefit package.

MEDICAL SOCIAL WORKER, PEDIATRIC SETTING: Extended Pediatric care setting desires social worker with MSW, ACSW, and 2 yrs pediatric medical experience to work as member of multidisciplinary rehabilitation team, working with wide range of diagnosis. Opportunity for involvement with family, agencies, patients and practicum students.

SOCIAL WORKER wanted for residential treatment center in northwest St. Louis county. Applicant should have M.S.W. Experience in residential treatment preferred, but not required. Applicant will work with a treatment team to facilitate the growth and development of a case load of 15-20 children. Job offers an opportunity to use counseling and administrative skills in a treatment-oriented setting.

These do not deviate far from our early traditions. If we look at the friendly visitors of the Charity Organization Society and the Settlement House Workers, it is clear they engaged not only in the case-by-case method but in community organization, policy and social reform activities.

At another point in our educational efforts, curricula have been structured according to populations at-risk and/or problem areas. Thus social workers are identifying themselves as child welfare workers, school social workers, psychiatric social workers, geriatric social workers, and so forth. It was as if we argued social workers who work with children in schools or a person in a senior citizens center, or a depressed individual in a mental health center overlook the similarities in the helping process.

Some schools for social work training have divided what social workers do into micro and macro practice areas. This dichotomy is too presumptuous. It suggests that social workers trained in micro practice function without awareness of policy and research. Similarly, it is assumed that macro practitioners have very little or nothing to do with actual practice with individuals, families, or small groups. While there have been a number of efforts[8] to attempt to categorize what we do in social work, the definition remains unclear. These efforts fail to recognize the great similarities in processes social workers employ in assisting individuals, families, small groups, or communities to improve their functioning and resolve societal problems.

ETHNOCULTURAL SENSITIVITY

Mental health services have been made available without regard to reality differences between black and white consumers. In an earlier study[9] utilization of community-based services for non-white consumers in a non-urban area of a southern state did not increase significantly, even when the community mental health center attempted to carry out the provisions of the Community Mental Health Centers Act. This Act was designed to enhance, among other things, greater utilization by blacks. Further, the percentage of black consumers referred to the state hospital failed to decrease significantly. This was true, even with the addition of the Baker Act which required at least 15 days of inpatient care in the community prior to referral to the state hospital. Blacks were diagnosed more seriously ill than whites and were offered the least autonomous forms of treatment. An increased number of blacks on the community mental health center board did not have any significant effect on service utilization by black consumers. These findings seem to be compatible with a national study by Windle, Neil, and Zinn.[10] They found a number of centers attempted to increase utilization rates of non-white clientele, by doing the following: 1) employing more non-white staff, 2) establishing outreach programs and satellite services, 3) including non-whites on the board of directors, 4) providing more minority workshops or inservice training, 5) setting up special committees to study "minority problems". Even with these efforts only 9 of 37 centers reporting showed any increase in utilization rates by black consumers. Significantly, few changes in treatment methods or alternate ways to deliver services were identified or employed. Misconceptions continue to play a dominant role in efforts to attract and maintain black consumers in treatment. It is my contention that the traditional methods of training obtained by the majority of mental health practitioners fails to recognize and accept specific ethnic and cultural sensitivities which might increase utilization rates. Of specific relevance for working with non-urban black consumers are informal and natural support systems, black formal organizations, and self reliance.

Non-urban blacks utilize informal systems within their communities much more frequently than their urban counterparts.[11] Whether by economic, social, and political necessity and/or lack of formal systems, a strong sense of family, religious orientation and close social ties with other persons in the community play an important role within the black community. Mental health

therapists and administrators must recognize these systems and establish a cooperative working relationship with them if utilization rates are to increase. While these systems are not always visible to an outsider, they exist nevertheless. These consist of indigenous leaders such as the preacher, church deacon, indigenous healers, general physicians, as well as leaders of local groups, such as sewing circles, burial associations, or fraternal organizations. Frequently, these persons are called upon to provide guidance and direction to couples with marital difficulties, problematic children, substance abuse problems and mental health problems.

In a study by Flaskerud & Kviz,[12] residents were presented with five health resources: 1) the general or family physician, 2) psychiatrists, 3) mental health centers, 4) drug abuse treatment centers, and 5) alcohol treatment centers. They found the following:

> "About twenty percent did not know if psychiatrists, mental health centers and alcohol treatment centers were available. Only 1.3 percent did not know if general practitioners were available. Based on the knowledge of availability, psychiatrists and drug abuse centers were available to one-third of residents, mental health centers and alcohol treatment centers to 40% and general or family practitioners to almost 90%."

Major demonstration projects[13] currently underway in rural Alabama and Missouri are attempting to utilize general practitioners (MD) as mental health resource persons. Through NIMH and NIH grants, social work students are placed in the offices of general practitioners. They perform many roles including: taking social and medical histories, providing clinical and non-clinical services, and educating doctors in mental illness symptomology and interventive approaches.

Indigenous healers will probably not collaborate with a mental health practitioner in treating a black clientele. However, evidence does suggest that they can play a major role if accepted as a part of the client's reality. References to these leaders and their role as helpers must not be frowned upon but recognized and accepted. This is especially important in those cases in which the black clientele feel their illness is unnatural. When these leaders and organizations are recognized and accepted as a meaningful part of the non-urban black's world, it is easier to involve them in a helping relationship.

Kinship systems are prevalent and essential to the day-to-day survival of non-urban black America. Carlton-LaNay and Majeed define these systems as consisting of blood relatives, relatives gained through marriage, play relatives, guard parents, friends and neighborhoods.[13] Kinship systems do not operate in times of crises but on a day-to-day basis with a sharing of goods and services. Unfortunately, this sharing is often viewed as "abnormal" by more impersonal providers. These systems and values must be recognized, respected and worked with, as the mental health practitioner attempts to help the black client work through his problem.

In a recent study of non-urban black Appalachians,[14] covering the Southern Appalachian region of Western North Carolina, Upper East Tennessee and Southwest Virginia, it was found that these residents tend to accept outside help as a last resort or when dictated to by some legal authority. Many view professional helpers with suspiciousness or as intruders. More importantly, they feel they can resolve their own problems. If help is needed, they tend to go to family, informal systems in the community, the minister or general physician.

GEOGRAPHY AND VICTIMIZATION

Potential black consumers residing in non-urban areas face "triple jeopardy" when it comes to receiving appropriate mental health care. These consumers not only find themselves victims of economic and procedural inaccessibility, but also suffer from physical inaccessibility and its ramifications. Great geographic distances with inadequate or absent public transportation, poverty, high unemployment, few human service agencies and inadequate resources are just some of the external realities faced by rural consumers.[15]

More specifically, non-urban black consumers, as well as whites, to a lesser extent, suffer from victim-blaming by the mental health establishment. Ryan, who has devoted a good deal of attention to victim blaming, suggests the process as follows:

1. Identify social problem,
2. Study those affected by the problem and discover how they differ from the rest of us as a consequence of their deprivation and injustice,
3. Define the differences as the cause of the social problem itself and,
4. Identify a government bureaucrat to invent a humanitarian action program to correct the differences.[16]

Therefore, when geographic inaccessibility and its consequences keep black consumers from receiving appropriate and adequate care, the system views this as being their problem. Note Bergstrand's findings on the maldistribution of rural physicians:

> Frequently those places where a definition of the social problem was forced into a socially constructed reality: informal gatherings in the private homes of consumer group members, rural community taverns and cafes, and other public gathering places where physician shortages were often a central topic of discussion. I also attended more formalized meetings between consumers and representatives of provider and planning interest groups. It was my clear impression that while the victim-blaming strategy was effective in drawing attention away from the medical school in these formal meetings with provider and planning interest groups, the ideology it rested upon was less than

> plausible to their victims. The opinion was expressed to me in numerous private conversations with these consumers that rural communities were being treated unfairly by those representing the interests of urban medicine. Due to the prestige of the victim-blamers and their apparently sincere humanitarian motives, however, ideological distortions of common sense reality which were obvious to the victims never became an issue in their confrontations with the victim-blamers. As a result, these distortions became an effective tool used by the victim-blamers to "manage" the definition of the situation.[17]

In Windle, Neil, and Zinn's study,[18] Region IV,[19] it was found to contain the largest number of non-urban white consumers and the highest number of federally-funded centers which served fewer non-whites than whites. This pattern occurs even when centers were located in close proximity of large black populations. See Table 1.[20] * When asked to develop plans to increase utilization by black consumers, centers identified a variety of activities which were similar to those mentioned earlier. The largest percentage of centers attempted to increase minority staff, establish satellite offices, expand their outreach activities and increase minorities on centers' boards. Very few provided transportation or used indigenous leaders or other black networks such as the media, social clubs and natural support systems. More importantly, less than five percent of the centers attempted to change their approaches to the delivery of clinical services.

Thus, training for practice in the mental health field tends to perpetuate the tendency of victim-blaming. It does not support differences of approaches or possible new ways of assessing problems in hopes that more appropriate interventions can take place.

In summary, we have seen how the effects of traditional education for social workers preparing to practice in the mental health arena has perpetuated economic, geographic and procedural inaccessibility. Specifically,

1. it has taken us from our commitment to delivery of services to all who need them,
2. it has resulted in a dual system of care by relegating a disproportionate number of black consumers to institutional rather than community care,
3. it has produced competing divisions of clinical and non-clinical services as if one has little to do with another,
4. it has failed to recognize that people usually meet their needs through informal and natural networks,
5. it has perpetuated the concept of victim-blaming of non-urban populations, and
6. it has caused few changes in approaches to the delivery of clinical and non-clinical services in non-urban communities.

* See page 13 for Table 1

Table 1

Percentage of Federally Funded Centers in Catchment Areas with High or not High Percent Blacks, by Region

	Areas with High % Blacks		Areas with Not High % of Blacks		Difference (favoring high)
Region*	N	% Funded	N	% Funded	% Black Areas
II	18	28%	151	23%	+ 5%
III	23	65%	152	36%	+29%
IV	50	42%	174	52%	-10%
V	25	32%	299	24%	+ 8%
VI	21	57%	123	37%	+20%
Others	12	58%	451	36%	+22%
Total	149	46%	1350	34%	+12%

*Taken from Charles Windle, Jeff Neal, and Harian K. Zinn.

If the foregoing analysis is reasonably correct, then education for community mental health practice in rural areas with black clientele as the primary target must bridge the aforementioned gaps. This training must be compatible with the traditional principles of social justice and override the dichotomy between generalist and specialist practice and result in an advanced generalist model. The following premises are proposed for the advanced generalist practice model:[21]

1. Community mental health practitioners must be able to practice as autonomous decision makers who can work with a wide range of systems and can practice easily and effectively with individuals, families, small groups,formal and informal organizations,
2. Training must be within a systems framework to make informed choices about intervention in multi-systems,
3. Training must focus on systems in trouble and/or problem to be solved or opportunity to be enhanced, rather than upon a traditional social work method,
4. Within the above context the objectives of practice are:
   a) helping people to increase ability to change situations and/or cope with negative aspects of their environment;

b) strengthening individual, family and/or community functioning in problem solving and resource acquisition needed in meeting problems;
c) helping individuals, families and communities obtain appropriate resources to maintain or enhance social functioning;
d) helping mental health and other organizations to be responsive to individual, family, and community needs and problem solving efforts;
e) facilitating linkages and interactions between persons and families, communities, societal institutions and formal and informal organizations;
f) influencing mental health policy impacting on those apt to encounter social problems;
g) facilitating linkages to other academic disciplines for interdisciplinary collaboration necessary for systemic change whether at the individual, family, group, small group or community level.

The advanced generalist model advocated consists of two years of social work training. The first year is composed of recognized core courses which offer knowledge, values and skills in human behavior and the social environment, generic social work practice, social welfare policy and services, research and field practice utilizing various modes of intervention practice with ethnic populations of color.[22] The educational outcomes of this foundation core should minimally include the following:

1. interpersonnel helping and interviewing skills;
2. knowledge of individual family,group, community and organizational behavior;
3. skills in scientific inquiry;
4. the role of policy visa practice;
5. use of general problem solving skills at the individual, family, group, and community levels, including problem and/or opportunity definition, goal formation, selection of interventive strategies and tactics, implementation and evaluation.

The second year is a concentration. The concentration provides students with in-depth problem solving skills and opportunities in the mental health arena. The concentration should consist of at least six required courses designed specifically to bridge the clinical and non-clinical skills and services gaps, enhance ethnic cultural sensitivity, and provide an understanding of the non-urban environment. Two of the required courses should be practice focused: 1. Advanced Clinical Practice which provides social work practice skills required to intervene on the behalf of and with individuals, families and small groups (including use of natural helping groups), 2. Advanced Non-Clinical Practice which provides skills required to engage in community practice, administration and planning (including linkage mechanisms to enhance utilization of services by groups who normally under-utilize mental health services). A third course should focus on Community Mental Health Policy and Program Issues, including history, policy-legislation, populations of color, and geographic impacts. Two courses should focus on research, one on evaluation, and the other on design and implementation of a research effort. The final two courses should cover a year of field practice in or related to a mental

health facility. The field practice must include integrated seminars in which all of the above can be implemented, integrated and internalized.

This approach views practice from a holistic perspective, negating the dichtomy of clinical and non-clinical practice.

To conclude, efforts to train social workers to cross traditional casework services with community services are beginning to take on more relevance in the social work curriculum. Successful outcomes are becoming numerous not only in mental health but in other practice arenas as well. While all the results are not yet in, it is obvious that traditional practice has generally failed in its efforts to deliver mental health services to black consumers living in rural and semi-urban areas.

FOOTNOTES

1. Curran, Thomas F. & Cox, Arthur J., "Linkage Strategies for Attracting 'Underserved' Populations to Community Mental Health Centers", Journal of Social Welfare, Fall 1979, p. 50.

2. Parks, R.E. & Burgress, E. The City: The Ecological Approach to the Study of the Community. Chicago: University of Chicago Press, 1952.

3. Cox, Arthur J. "A Black-White Compassion of Differential Diagnosis & Treatment Modalities in a Community Mental Health Center Over Time", Black Caucus Journal, Vol. 10, No. 1, Spring 1979, p. 5.

4. Lorian, R.P. "Socio-economic Status & Traditional Treatment Approaches Reconsidered," Psychology Bulletin, Vol. 29, No. 2, Fall 1973.

5. Jones, B.E. "Problems of Black Psychiatric Residents in White Training Institutions," American Journal of Psychiatry, 1970.

6. Ibid.

7. Cox, Arthur, J. "Social Work Job Announcements: Generalists vs Specialists," St. Louis Post Dispatch, Sunday Editors (12-82 - 7/83).

8. See Crompton & Gallaway, Bauer & Federico, and Pincus & Minahan Texts.

9. Cox, Arthur, J., "A Study of Differential Utilization Patterns in a Community Mental Health Center," unpublished DSW Dissertation, Columbia University School of Social Work, New York, 1977, Chapter 4.

10. Windle, C., Neal, J. & Zinn, H. "Stimulating Equity of Services to Nonwhites in Community Mental Health Centers," Community Mental Health Journal, Vol. 15, No. 2, 1979, p. 163.

11. Carlton-La Ney, I. & Majeed, S. "Education for Practice with African Americans in Rural Areas," Author's Forum, Annual Program Meeting Council on Social Work Educators, Fort Worth, Texas, March 1983, p. 5.

12. Flaskerud, J. & Kriz, F.J. "Resources Rural Consumers Indicate They Would Use for Mental Health Problems," Community Mental Health Journal, Vol. 18, No. 2, Summer 1982, p. 112.

13. For further information, contact Charles Atherton, University of Alabama and William Butterfield, Washington University in St. Louis, Mo.

14. Cox, Arthur J. "Black Appalachian Families' Perspectives on Social Change," in Dignity, Diversity and Opportunity in Changing Rural Communities, edited by Lynn Morris, p. 156.

15. Windle, Neal and Zinn, p. 163.

16. Ryan, R., "Victim Blaming," Social Forces. Vol. 27, No. 1, October 1979, p. 62.

17. Bergstrand, C., "Victim-Blaming and the 'Looping' Effect of Social Policy: The Case of Physician Maldistribution and Underserved Rural Communities," Social Problems, Vol. 27, No. 1, October 1979, p. 62-65.

18. Windle, Neil & Zinn, p. 163.

19. Region IV consists of the following states: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina and Tennessee.

20. Op. cit., p. 163.

21. Premises 1, 2 & 3 taken from Self-Study Working Document School of Social Work, University of Southern Mississippi, Spring 1982.

Expanding Clinical Social Work Roles: Non-Traditional Approach to Rural Aging

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Clinical social work practice in rural areas is undergoing change. There have been numerous program and budget cuts. Federal pressures have pushed practice away from a needed generic service and towards clinical specialization since psychotherapy is reimburseable. Furthermore, social work training has emphasized specialization. Social workers in rural settings are often faced with few colleagues and with many cases needing different services and different treatment modalities.

In North Carolina, 60% of the population is rural, compared to a national figure of 26%; among the state population, 10% is over 65 years of age. Of this group, 23% are below the poverty guidelines. In North Carolina, 20% of the aging are members of a minority group, compared with 12% nationally.[1] Thus, in North Carolina, the aging tend to have a greater number of risk factors such as being rural, poor, and a minority group member. All of these factors increase the likelihood of illnesses.

How can social workers in rural practice approach this population group? This paper begins with a description of the limitations of a traditional clinician's role, includes a description of the special mental health needs of the elderly, and concludes with a proposal for a generic social work model for meeting these needs. An aging activity group case illustration is presented, utilizing a problem-solving method with generic intervention techniques.

The traditional clinical role is based on the medical model of providing diagnostic and psychotherapeutic services to individuals, families, and groups, emphasizing "modifying maladaptive relational skills and increasing the client's ego strengths."[2] Concrete services, such as locating resources, making referrals, coordinating and managing a person in the community, being an advocate, and organizing new services, are often defined as the responsibility of other agencies. Mental health clinicians faced with increasing demands of agency settings and diminishing community resources, may only have time for traditional services.

In principle, clinical social work's origins of treating the "person in the situation" suggest a generalist approach to the client or patient.[3] Stren states that "psychotherapy plus" should include efforts "to modify those forces in the client's environment which hinder his personal and interpersonal functioning."[4]

MENTAL HEALTH AND RURAL ELDERLY

For all age groups in rural areas, there are many barriers to receiving mental health care.[5] Some of these are: (1) Stigma of receiving formal mental health care, (2) Insufficient knowledge about existing services (3) Low funding of services offered, (4) Fear of loss of confidentiality, (5) Transportation problems, (6) Utilization of family or clergy for mental health care, (7) Cultural clash between worker and patient, (8) Utilization of inappropriate therapeutic methods, (9) Community resistance to psychological problems.

The rural elderly have other risk factors which increase their potential for mental illness. Being rural, they are subject to the above-mentioned barriers to receiving care. Being elderly, they have additional complications: (1) poverty, (2) poor health, (3) decreased self-image and self-sufficiency, (4) communication difficulties, loss of hearing, confusion, etc., (5) ageism and discrimination, (6) children leaving home, (7) major losses of spouses and friends, (8) loss of social status.[6]

Considering these risk factors for the rural elderly population, it is understandable that they are highly prone to psychopathology. It is encouraging that the majority of the rural elderly remain mentally healthy and continue to function and enjoy their environment. For those who are less fortunate, it is important to understand the special mental health problems of the elderly before interventions can be planned.

The age group of 65 and older is prone to four major categories of pathologies: dementia, depression, psychosomatic disorders, and paranoid symptoms. At times these pathologies present in combinations.[7]

Dementia is the most prominent mental health problem for individuals over age 65. Studies of rates of this disorder vary, but approximately 2% of elderly are severely impaired and 4% are moderately impaired. The incidence rates increase with age. Most cases are diagnosed as arteriosclerotic dementia, or Alzheimer's disease. The majority of patients with dementia live in their homes and are cared for by family members. Patients with dementia may be treated at health agencies or mental health centers.[8] Dementia must be distinguished from "pseudo-dementia," or depression or vitamin deficiences. While medication can help depression and psychotic symptoms but for dementia alone, we must concentrate on supporting the family and using generalist social work methods.

Severe depression presents in approximately 3% of the elderly and moderate/mild depressions presents in approximately 20%.[9] Field interviews identified a higher incidence of depression than reported in treatment records. Depression in the elderly can present in the typical ways of sad affect, sleeplessness, fatique and in atypical ways, such as, agitation, pseudo-dementia, alcoholism, and suicide attempts. Between 2 and 10% of psychiatric outpatient elderly are alcoholics and between 5 and 15% of medical outpatients are alcoholics.[10] Suicide rates for the elderly are surprisingly high with

over a third of the adult suicides occurring in older persons, despite their composing only one eighth of the population.[11] Family members and clinicians often place less importance on depressions of the aging, assuming sadness and decreased activity to be a normal state for the elderly.

Patients with somatoform disorders, including hypochondriasis and chronic pain, are usually resistant to the concept of psychological causes. They tend not to present for mental health treatment and are often managed by general physicians.[12]

Paranoia and other psychotic symptoms may occur as common mental health problems of the aging. Paranoia may be seen alone or in relation to dementia. Suspiciousness often rises as an older person's functioning in hearing and vision decrease.[13]

SOCIAL WORK PRACTICE AND RURAL ELDERLY

How can a social worker respond to the mental health problems of rural aging clients? Germain and Getterman suggest a "Life Model" of social work in which the worker addresses three areas of stress-producing problems for the patient: life transitions, environmental pressures, and interpersonal processes.[14] The worker responds to the problems and concerns of the patient rather than allowing the agency or the worker's own preferences to dictate the treatment choice. Mulcaccio, (et al.), emphasizes the partnership element of the client-worker relationship, with workers functioning as enablers. Life experiences are used as growth and developmental tasks to strengthen the adaptive capacities of the patient.[15]

Utilizing the concepts of this model in a generalist social work practice, the social worker remains a clinician focusing on mental health problems. In addition, four other roles are appropriate for an effective rural mental health worker: community organizer, health educator, researcher, case manager.

The community organizer role can be useful for focusing on the environmental pressures and for effecting a patient's social milieu. Some skills include: data collection, informal and formal interviews, community informants, and human services analysis.[16] Community analysis can reveal strengths which may be applied to building social networks to augment individual treatment. The worker may want to increase existing interagency coordination and mental health advocacy or design new treatment programs. Agency public relations efforts may be as a means of case-finding by increasing public awareness and decreasing the stigma of associated with mental health services. The worker may identify community leaders or "indigenous consultants" to assist in treatment implementation and facilitate self-help groups such as an Alzheimer's Family Support Group. By identifying and convening persons with similar problems, the worker can utilize community efforts to augment individual treatment.

As a health educator, the worker can use the community meetings and workshops to present mental health information in non-clinical settings.[17] The clinician can function as a consultant on mental health issues.

Clinicians need to be researchers and document clinical methods and interventions. Some ways include literature reviews, case reports, or program evaluations with client self-assessment tools. These reports may document treatment effectiveness as well as provide information for other professionals.

The case manager role may incorporate previously described functions. Case management functions are assessment, planning, linking to other services, monitoring progress, and advocacy for the client. In mental health settings, the case manager role may encompass the psychotherapeutic role as well as case management functions.[18]

The generic social worker in rural areas, might utilize techniques from different intervention modalities in order to enhance their effectiveness in treating patients.

CASE EXAMPLE -- SENIOR CITIZEN ACTIVITY GROUP

The social worker in the rural health clinic where the group was conducted, fulfilled job assignments of social worker and mental health worker. The assignment included providing direct individual patient services. Using a problem solving method, the worker identified additional methods of intervention.

Step 1 - Defining the problem. In the first six months, approximately 39% of the referrals to social services/mental health were persons over 55 years of age. These aging patients frequently presented with depression, chronic physical illness and socioeconomic stresses. Many patients over 55 years old came weekly to the clinic. The social worker noticed patients socializing with friends and clinic assistants in the lobby and then complaining to health providers of pains and depression.

The social worker began to identify stresses for this group, notably low income, loneliness, loss of spouses, and few services available.

The clinic's solutions to assisting elderly with the problems presented was offering traditional individual casework, psychotherapy and chemotherapy. This has been well received for one or two sessions, but not for long term intervention. Networking was attempted on individual case basis with limited success.

Step 2 - Defining possible solutions. The social worker initially proposed a special "Geriatric Clinic Day" with special services, education, consultation available. Clinic staff felt this proposal was impractical for a small facility.

As a second proposal, the worker suggested, that the clinic sponsor an activity-centered senior citizen's group. This group would be for high functioning community members with clearly identifiable health and emotional health problems, such as depression and loneliness. It would be designed to help members utilize strengths and learn new socialization skills. The social worker asked a clinic nurse, long time community member, for her assistance. She became involved by making connnections with prospective members and ascertaining their interests.

Step 3 - Offering new treatment. The clinic social worker shared the organizing task and convened planning sessions for agency representatives, clergymen, and aged community members. With the worker acting as facilitator, plans were finalized during weekly activity meetings. The Senior Citizen Club was to meet in a neutral place and not be racially or denominationally connected. The 31 persons in attendance at the first meeting participated enthusiastically by planning further activities, volunteering contributions for food and treasury and opening the membership. The social worker's role was to locate resources including staff time, facilitate meetings, and act as a consultant for arranging monthly health and mental health educational programs.

The group has continued to meet at least weekly for two years with an average attendance of 25. In addition the group sponsored monthly trips. Through sale of group-made quilts and brunswick stew, the group has over $3,000 in the treasury. Encouraged by the social worker, a generalist natural helping network of group members emerged around material and emotional needs.[19] Networking was especially focused on those persons identified by the clinic staff and group members as needing psychosocial support. Patients are treated in their own "life space."[20]

Step 4 - Evaluation. Early in the history of the group, the worker perceived a shift in attitude toward clinical services. Group members were willing to accept social and informal mental health services. The worker recorded actual effects on her caseload which showed an increase in the elderly served. Group members were involved in continual evaluation by planning their group activities.

In a more formal program evaluation, group members were asked to evaluate the group on a subjective questionnaire, administered after seven months of operation. Responses were overwhelmingly positive. 66% of the respondents (26 people) answered that the group either "very important" or "the most important activity in my life." 95% had made new friends at the group. 27% (nine of the 33 answering the question) stated that their feeling of loneliness had decreased since the group started. Group members indicated that their favorite part of the group experience was general socializing, not activities or trips.

The senior citizen group has effected health status and health care. Clinic staff members believe that community members have decreased their clinic socializing visits and have increased their knowledge of health issues. The worker decided that documentation of the change in health care visits would be indicative of the group effect. In conducting a medical chart review, preliminary results suggest that actual number of visits to the clinic has not

been reduced substantially. However, the reasons for the visit are less likely to be mental health related and are more likely to be medically related.

The group appeared to be a positive experience for group members, specifically those patients who were depressed. The social worker realized that the group was not meeting the needs of the patients with dementia. In the first identification of patients, there was only one identified with dementia. Slowly, the number of persons with dementia began to rise and a different treatment service was needed.

Step 5 - Making adaptations of the new treatment. Patients with dementia were utilizing excessive medical and psychiatric staff time. Family members were experiencing symptoms of stress, anxiety, and depression from caretaking chores. Choreworker funds were limited, and nursing home beds not available. After a more thorough casefinding, ten patients were identified as having dementia. An Alzheimer's and Related Disease Family Support Group has begun meeting to share experiences and to obtain support and to hear speakers on pertinent topics.

Rural mental health social workers have a responsibility to expand their practice into specific services for the elderly. Utilizing a "Life Model" of social work,[21] this paper advocates a generic method of practice in which the worker views the aging client as a partner in his/her own treatment and attempts to use multiple service modalities to accomplish clinical goals. Expanded roles can include: community organizer (to develop services), health educator, research (to justify the effectiveness of less traditional treatment methods), and case manager (to monitor patient progress and locate new resources).

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Alternative Interventions in a Rural Mental Health Center

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During times of fiscal restraint, mental health workers are looking for new ways to provide and improve essential services for clients. Rural mental health practitioners have been faced with cutbacks of funding, personnel and other resources essential to program quality. Research has shown that the traditional "therapist-client" care is not well suited to the mental health needs of rural populations. Considering these issues, we will discuss our experiences in providing alternative care to rural Mental Health Center clients, including advantages, disadvantages, and feasibility of this type of care.

Our formal work with alternative care began in 1981, when the Chatham County Mental Health Center agreed to participate in a three-year National Institute of Mental Health study conducted by the Department of Community Psychiatry of the University of North Carolina School of Medicine. The principle investigator, William G. Hollister, was interested in studying the effect of alternative care as compared to traditional clinical intervention on client improvement, cost factors, client satisfaction and staff satisfaction. The two separate groups in this study provided an opportunity to identify and evaluate two different types of strategies and interventions used in a rural mental health center. This paper will address research design and process but focus on alternative care and at the community mental health center.

For the purpose of our study, we defined alternative care as interventions that were not primarily intrapsychic-oriented psychotherapy or pharmacotherapy. Available alternative care interventions include:

1. Self-help mutual aid group without professional leadership to provide support, education and resource mobilization.

2. Group mental health education experiences, both cognitive and affective.

3. Mental health education to meet specific client needs.

4. Formal social support services, such as Girl Scouts and AA.

5. Informal social support services, such as the mental health worker assisting the family in providing a support for the client.

6. Rehabilitation services to improve or restore a person's functioning in society, such as skills of leisure time training, partial hospitalization, and sheltered workshops.

7. Crisis services in emergencies.

8. Home care in own home or an alternative residence to help maintain a person, such as homemakers or public health nurses.

9. Personal services such as money management, shopping aid, legal aid, tax preparation, nutritional and recreational services.

10. Case management planning, mobilizing and monitoring resources and care for the client. (Hollister 1983)

The staff were encouraged to operate freely in the community, learning about available resources, connecting clients with these resources, and developing new resources, such as self-help groups and educational guides. We realize overlap between clinical care and alternative care. However, we believe that the difference lies initially in the client-worker relationship. Alternative care defines the worker as "educator," not therapist and the client as "student" rather than patient. In constrast to traditional care, the focus is not on transference, pathology, and weakness but rather on inherent strengths and the learning of growth producing, new behaviors.

At this point, we need to mention that our use of non-clinical interventions is not completely new. In fact, we found that many clinicians will supplement their pharmacological and therapeutic care with a variety of other interventions ranging from self-help to social support. These services are often provided in an unstructured, informal way. Our project marks a concerted effort to formalize, streamline, and develop these techniques, materials and resources into a usable and educational format. We hope that alternative care will augment and at times supplant traditional mental health care in a manner appropriate for rural settings.

Alternative interventions are rarely formally recognized by administrators at the time of budgeting and hiring personnel. It is increasingly expensive to follow the "medical" model in providing mental health services. Non-traditional programs for mildly impaired persons may prove to be both cost-effective and satisfactory in meeting client needs. As it becomes more acceptable for rural clients to utilize mental health centers, we must find ways of providing help within the contextual and budgetary framework of the agency.

In order to assess the feasibility of alternative care, we placed all new mental health admissions of persons with milder problems into either an alternative treatment program or the more traditional standard clinical care. This was random. It was necessary to obtain permission from the client before he/she was enrolled in the study. Clients who agreed to participate in the study were told that they would be expected to participate for the next six months even if the treatment plans were

completed prior. The client was evaluated via two worker ratings, one self-report and the report of a significant other person in the client's life. Cost data forms were completed to evaluate how the time of the client, therapist, staff or community persons were spent in delivering or receiving treatment.

In the provision of any care, it is advisable to involve the client in selecting the method of treatment. In order to enhance the individual's interest in helping themselves, it is necessary for the worker to provide the client with some ownership of treatment plans. To a greater degree than usual with clinical care clients, we involved our alternative care clients in assessing behaviors for change or areas of their lives for improvement in. In addition, we would learn about a client's family and supports by visiting them at home or in the community. As the client identifies an initial list of problems for focus, it might be necessary to meet with them weekly. Once the initial treatment plan is determined, the client and staff person generally decrease the frequency of sessions to once or twice per month. Sessions involve reviewing recent events in the client's life in terms of the treatment plan, discussing various written "homework" assignments which are an integral part of our written learning guides, or perhaps viewing a pertinent filmstrip or exchanging one educational tape for another. As much as possible, we encouraged clients to utilize their own personal resources or community resources, such as spending time with friends, joining an exercise class, participating in church groups or participating in self-help groups. Our intention is for most client learning, change, and self-improvement to occur outside of the mental health center. In some cases, clients involved in an alternative care treatment program have organized a support group to help themselves and others with a particular problem or issue. Staff from the mental health center have been available as consultants to share their expertise to these developing groups.

After six months, clients interested in further learning were transferred to a clinic therapist if they received alternative care or continued with the same clinic therapist without restrictions of the study.

At this point, it is pertinent to discuss alternative care as it applies to rural minorities. First, in discussing the provision of mental health services in a rural area of North Carolina, one is often discussing the provision of services to minorities. Second, mental health centers tend to be underutilized or poorly utilized by minority clients who live in rural areas. This may be due to the fact that traditional mental health services may not meet the needs of these clients. Third, for many of these people, going to the mental health center is an alternative intervention. In rural areas there is a high value placed on self-sufficiency. In general, it is acceptable to deal with one's problems internally or utilize natural support systems, such as friends, family, or the local minister. For many people seeking services from a mental health clinic is a last resort. The alternative care approach is appropriate for the rural setting because it is more socially acceptable than traditional care and may meet certain client's needs better. The need for frequent client-worker contacts to develop the traditional therapeutic relationship may be reduced. We believe

that learning taking place in the client's own environment might be more efficient and provide greater opportunities for carryover into other spheres of their lives.

Persons of various educational backgrounds have been involved with the study and its clients. The program had some initial difficulties in having staff change their existing roles. Two staff members of the Chatham County Mental Health Center, a health educator and a clinical social worker, comprised the Care Support Team. Their functions were to design and implement alternative care treatment plans, administer research data collection, and assist staff in working with alternative care clients. As the study progressed, clinic staff became more comfortable with providing alternative care.

In adjusting to provide non-traditional care, clinicians may be placed in paradoxical situations. Some of the resistance to assuming a non-traditional role may be that one is trained to provide care in a particular manner, and any deviation from that norm requires a redefinition of the traditional therapist role. In terms of our research, it is necessary for the clinician involved in providing alternative care to give up the power inherent in the role of therapist. This may force the clinician to address issues with the client which are radically different than if a more clinical approach were utilized. Someone whose vehicle of client change is a weekly hour of insight-oriented psychotherapy is probably not going to be comfortable handing the client a book about divorce or a relaxation tape. This alternative intervention may be without the "benefit" of what the clinician has been trained to provide. Ethical questions raised by this issue have been addressed elsewhere, and are worthy of further consideration. (Rothman 1983)

Some preliminary data from March 1983, concerning the outcome of clinical and alternative care from our sample group of mildly impaired clients, is now available. As noted earlier, assessments are from the perspective of the individual, a significant person in his/her life, and the mental health worker. The results suggest that both clinical and alternative care clients improved significantly, particularly during the first three months after initial contact with the center. There seems to be a trend towards more improvement in the alternative care clients than clinical care although this is not statistically significant. Regarding staff satisfaction, 97 percent of the staff expressed support or enthusiasm for the concept of alternative care, while 76 percent responded favorably to the research project. (Hollister 1983) In addition, over 75 percent of the staff said that alternative care methods were acceptable to their clients. Many of the staff felt alternative care was adequate to meet mental health needs of mildly impaired persons.

Where have the last three years led us? Hopefully to a greater understanding and appreciation of the power and utility of non-traditional interventions in a rural mental health setting. In addition, it is possible that alternative care provides the same results for less money. We feel confident that alternative care, causes little disruption in the lives of clients and facilitates personal growth.

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Minority Women and Depression - A Pilot Study

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It has been estimated that 40 million Americans show some degree of depressive symptomatology and that two-thirds of this group are women (Baskin, 1981). Klerman and Weissman estimate that 20-30 percent of all women will experience periods of depression at some point in their lives. Numerous studies show that this overwhelming statistical difference between males and females for incidence of depression is not an artifact of social discrimination, biological predisposition or genetic factors, but is nonetheless "real" and can perhaps be accounted for by a variety of subtle and complex factors (Klerman & Weissman, 1980).

Of particular relevance to this paper is the comparison of rates of depression between minority women and other groups in the population. Race has been found to be an insignificant factor in predicting psychopathology. In fact, when socio-economic status is statistically controlled, there is no differences between whites and minorities for incidence of mental illness, including depression (Warheit, 1975). However, minority status does appear to affect diagnosis. Baskin notes that while women have higher rates of depression than men, whites are more frequently diagnosed as depressed and that all women regardless of race are more often diagnosed as depressed. Minority women are also diagnosed as alcoholic and schizophrenic more often than white women (Baskin, 1981). Baldwin found that non-white males and females were more likely to be diagnosed as psychotic compared with white males and females in the same age group (Baldwin, 1975). Olmedo showed that schizophrenia was the leading diagnosis for black women but was the last choice of diagnosis for white women (Olmedo, 1981). Other studies have demonstrated that when clinicians are presented with data that do not indicate race of client, no significant differences were found in frequency of one diagnostic category over another (Simon, 1973; Krebs, 1971; Blake, 1973).

It appears that decisions about treatment are affected by race and sex of client. Minority females receive crisis intervention as a form of treatment more often than other client groups (Krebs, 1971). Black clients, in general, receive more medications and particularly prescriptions of hypnotics and minor tranquilizers (Cole, 1976; Raskin, 1975). Statistics show that 71 percent of all prescriptions written for antidepressants are for women (Fidell, 1981). It can be expected that minority women receive more prescriptions for antidepressants than men, and that they receive more prescriptions for hypnotics and minor tranquilizers than do white women.

Some studies have shown that minority clients, particularly black women, have high rates of premature termination of psychiatric treatment (Andrulis, 1971). Wilder found that black women are less likely to make and keep psychiatric appointments following referral by a hospital emergency room, at the rate of 28 percent as compared to 66 percent of the white women referred to treatment (Wilder, 1977).

In summary, minority women are often diagnosed as depressed but are also more likely than white women to receive a diagnosis indicating more severe pathology. They are likely to drop out of treatment sooner than other groups, and to be treated with supportive psychotherapies and medications, particularly hypnotics and minor tranquilizers.

In view of the current literature, a pilot study was undertaken to examine the diagnosis and treatment of minority women at a rural community mental health center. Based on previous studies, the data were expected to show that minority women receive prescriptions for minor tranquilizers and/or hypnotics more often than other groups; and are more likely to receive multiple prescriptions when compared to client groups with similar diagnoses. Minority females were expected to be found to stay in treatment for a shorter period of time and receive a supportive type of treatment.

METHOD

Subjects

One hundred nineteen subjects were chosen for this study. All had been seen in the Adult Services Unit of the Vance County Mental Health Center for at least one session during the seven years prior to the beginning of the study (1983). The mental health program is in a rural area of North Carolina and is the only outpatient psychiatric facility in a 35 mile radius.

Procedure

Information for the study was obtained from closed client records. Ethnic, gender, employment, marital, age, and income characteristics were gathered from the admission data in each record which is completed by clerical personnel at the time of admission. Medication information was found on a special medical history form in the record. Treatment and diagnostic information were taken from the client's termination summary prepared by the primary therapist for that case. Only those clients who received a diagnosis of depression (i.e. psychotic depression, adjustment disorder with depressed mood, major depression or dysthymic disorder) were chosen for the study. Number of client visits and number of times the client had been seen for treatment and terminated were found on a "record of client treatment" sheet.

Of the 119 subjects, 14.3 percent were non-white males, 25.2 percent were white males, 30.3 percent were non white females, and 30.3 percent were white females. Roughly half of the client sample was employed with no significant difference in employment status by sex and only a small difference by race, with non-white clients being unemployed at a slightly higher rate. The median age for the sample was 33 years. Female clients were somewhat older than the male clients with no difference by race. In terms of marital status, 75 percent of the minority female clients were widowed, separated or divorced, as compared with 55.6 percent of the white females. There were 64.7 percent of the non-white males who were not living with a spouse, as compared with 46.7 percent of the the white males. Very few of the clients had been seen at the Mental Health Center for more than the initial admission, although the number of client

visits ranged from one to ninety-eight with a median of 5.7 interviews. Most clients in this sample were seen only once and the average number of interviews was 10.96. There was no significant difference in number of years of education across groups, although non-white clients had roughly half the yearly income of white clients with no difference by sex.

Results

The relative frequency of the four diagnostic categories by race and sex cross-tabulations is shown in Table 1. The majority of clients received the diagnosis of dysthymic disorder, and 85 percent of those were male clients. Women clients tended to receive the diagnosis of adjustment disorder with depressed mood more often that their male counterparts. The only clients to receive the diagnosis of psychotic depression were non-white females (4.2 percent of the sample).

Table 1: Client Race and Sex and Diagnosis

Client Group	Diagnostic Group				
Group	Dysthymic Disorder	Major Depression	Adjustment Disorder	Psychotic Depression	Total
Non-white males	14 (82.4%)	2 (11.8%)	1 (5.9%)	0 (0.0%)	17 (14.3%)
White males	26 (86.7%)	4 (13.3%)	0 (0.0%)	0 (0.0%)	30 (25.2%)
Non-white females	25 (69.4%)	2 (5.6%)	4 (11.1%)	5 (13.9%)	36 (30.3%)
White females	25 (69.4%)	8 (22.2%)	3 (8.3%)	0 (0.0%)	36 (30.3%)
Total	90 (75.6%)	16 (13.4%)	8 (6.7%)	5 (4.2%)	119 (100.0%)

Table 2 presents the type of therapy each group received. White clients were slightly more likely to receive insight-oriented psychotherapy than minority clients (12.1 percent compared with 3.8 percent.) However, 85.7 percent of all clients were in supportive psychotherapy at the time of termination. Data were analyzed for the number of client visits to the facility as well as how the client terminated treatment (whether client and therapist agreed that therapy should end or the client decided not to return and "no-showed" for the next scheduled appointment). Insight-oriented psychotherapy was defined for purposes of this study as long-term (more than 40 sessions), although it could encompass shorter-term therapy in view of client termination, if the goals were personality change and insight. The methods were exploration of client dynamics and interpretation of transference material, dreams, and unconscious material. Problem-solving psychotherapy was defined as a short-term treatment where re-education and clarification of the problem was the main focus. Behavioral change was the primary goal. Supportive psychotherapy was

defined as short-term (fewer than four sessions) or occurring over a long period of time, but had the purpose of maintenance of medication, crisis intervention, and supporting and strengthening defenses. The focus was on the presenting complaint and alleviation of symptoms.

Table 2: Client Race and Sex and Type of Therapy

Client Group	Therapy			
Group	Support	Problem-Solving	Insight	Total
Non-white males	17 (100.0%)	0 (0.0%)	0 (0.0%)	17 (14.3%)
White males	22 (73.3%)	3 (10.0%)	5 (16.7%)	30 (25.2%)
Non-white females	32 (88.9%)	2 (5.6%)	2 (5.6%)	36 (30.3%)
White females	31 (86.1%)	2 (5.6%)	3 (8.3%)	36 (30.3%)
Total	102 (85.7%)	7 (5.9%)	10 (8.4%)	119 (100.0%)

Table 3 shows the mean number of interviews for all groups by type of termination. Those clients who followed their therapist's recommendation with regard to length of treatment tended to stay in treatment for an average of six more sessions as compared with those who "dropped out." White clients tended to stay in treatment for more sessions before deciding not to return. White males were seen in the most sessions before the decision was made by client and clinician to stop treatment. White female clients seemed to stay in treatment for approximately the same amount of sessions, whether or not they dropped out. Eighty percent of clients dropped out of treatment. Non-white clients dropped out at a slightly higher rate than white clients. On the average, black clients were seen less than half the average number of sessions that white clients were seen (6.7 sessions as compared with 14.4 sessions) regardless of termination status.

Table 3: Client Race and Sex
and Number of Interviews and Type of Terminations

Client Group	Mean Number of Interviews	
Group	Dropped Out	Mutually Terminated
Non-white males	6.1	3.5
White males	13.2	21.8
Non-white females	5.8	15.4
White females	13.6	13.4
Total (mean number of interviews)	9.7	15.8

Medications were administered to clients as shown in Tables 4A and 4B. White males were more likely to be prescribed antipsychotic medication without being diagnosed as psychotically depressed whereas non-white females (the only subgroup to receive the diagnosis of psychotic depression) were more likely to be treated with a combination drug and/or antidepressant rather than anti-psychotics. White clients were slightly more likely to receive minor tranquilizers than were non-whites. Non-white females received the fewest prescriptions for minor tranquilizers and the third fewest number of prescriptions for hypnotic drugs. The class of drugs to be presribed most often was antidepressants and this occurred across all diagnostic categories regardless of race and sex.

Table 4A: Client Race and Sex and Medication

Client Group	Medication				
Group	Anti-Depressant	Anti-Psychotic	Combination	Hypnotic	Minor Tranquilizer
Non-white males	8 (47.1%)	1 (5.9%)	0 (0.0%)	2 (11.8%)	2 (11.8%)
White males	18 (60.0%)	5 (16.7%)	5 (16.7%)	3 (10.0%)	7 (23.3%)
Non-white females	22 (61.1%)	0 (0.0%)	5 (13.9%)	4 (11.1%)	4 (11.1%)
White females	20 (55.6%)	2 (5.6%)	3 (8.3%)	5 (13.9%)	6 (16.7%)
Total	68 (57.1%)	8 (6.7%)	13 (10.9%)	14 (11.8%)	19 (16.0%)

The data for multiple prescriptions are shown in Table 5. White males were the least likely of all groups to receive no medication. There was no difference between groups by race or sex when at least one medication was precribed.

In an effort to understand what group of clients is most likely to stay in treatment and follow therapist's recommendations, termination status was correlated with diagnosis and type of medication prescribed. It was found that for all groups, diagnosis was not a good predictor for type of termination. However, as the number of medications prescribed increased, the average number of sessions increased. Clients who took no medications were seen on an average of 6.5 sessions, while clients taking one or more drugs were seen for 12.5 sessions. The differences for type of medication were statistically significant. Clients taking an antidepressant stayed in treatment for an average of twice as many sessions as those who did not. Those clients taking anti-psychotic medications were seen for almost three times more sessions than those who were not, and those taking a combination drug were seen an average of four times more sessions. There was no difference for hypnotic drugs or minor tranquilizers.

Table 4B: Client Race and Sex, Diagnosis and Medication

Client Group	Medication				
Group & Diagnosis	Anti-Depressant	Anti-Psychotic	Combination	Hypnotic	Minor Tranquilizer
Non-white male					
Dysthymic disorder	7	1	0	2	1
Major depression	1	0	0	0	0
Adjustment disorder	0	0	0	0	1
White males					
Dysthymic disorder	17	4	5	1	7
Major depression	1	1	0	2	0
Non-white females					
Dysthymic disorder	17	0	1	3	2
Major depression	1	0	0	0	0
Adjustment disorder	1	0	0	1	2
Psychotic depression	3	0	4	0	0
White females					
Dysthymic disorder	15	2	2	5	6
Major depression	5	0	0	0	0
Adjustment disorder	0	0	1	0	0
Total	68	8	13	14	19

Table 5: Client Race and Sex and Number of Medications

Client Group	Number of Medications					
Group	0	1	2	3	4	Total
Non-white males	6 (35.3%)	9 (52.9%)	2 (11.8%)	0 (0.0%)	0 (0.0%)	17 (14.3%)
White males	3 (10.0%)	18 (60.0%)	7 (23.3%)	2 (6.7%)	0 (0.0%)	30 (25.2%)
Non-white females	10 (27.8%)	19 (52.8%)	5 (13.9%)	2 (5.6%)	0 (0.0%)	36 (30.3%)
White females	11 (30.6%)	18 (50.0%)	4 (11.1%)	2 (5.6%)	1 (2.8%)	36 (30.3%)
Total	30 (25.2%)	64 (53.8%)	18 (15.1%)	6 (5.0%)	1 (0.8%)	119 (100.0%)

Discussion

The literature has suggested that minority women frequently receive mental health treatment that is different from that provided to other groups because of their gender and racial status. Minority women have been shown to receive crisis intervention services more often and to terminate treatment sooner than other groups. However, this investigation found that these minority women did not differ from other groups in their likelihood of receiving supportive psychotherapy, although minority clients in general were somewhat less likely to receive insight-oriented psychotherapy than white clients. Minority clients were seen for only half the number of sessions as white clients but dropped out of treatment at only a slightly higher rate. Further study might examine race of therapist and therapist's expectations as influencing the number of therapy sessions for minority clients.

This study also examined the issue of prescribing psychotropic medications to minority women. It shows that these minority females are not more likelty to receive multiple prescriptions than other groups, nor are they more likely to receive prescriptions for hypnotic drugs or minor tranquilizers. However, the minority women were less likely than white males to receive prescriptions for antipsychotic medications, even when diagnosed as psychotically depressed. It is possible that white males may be perceived by clinicians as more anxious, agitated and threatening and therefore are more likely to be prescribed major tranquilizers (antipsychotics) along with antidepressants. Minority females, on the other hand, may be perceived as less threatening and able to benefit more from one of the combination drugs such as Triavil and Etrafon.

As the literature shows, minority clients are more likely to be diagnosed as severely ill (Baldwin, 1975; Olmedo, 1981; Cole, 1976; Blake, 1973; and Simon, 1973). This study corroborates those findings in that only minority females received the diagnosis of psychotic depression. It has been suggested that this occurs because of racial bias in the diagnostician. However, this may be the result of more severe pathology being tolerated in minority females for longer periods of time (Andrulis, 1977). If this is the case, one could assume that minority females are brought in for treatment only when their symptoms become unmanageable or intolerable to family members, employers or the community. With other groups, symptoms of psychotic depression such as severe social withdrawal, loss of interest, and mood changes may be labeled as unacceptable and treatment is more likely to be sought at an early stage when the diagnosis of major depression with psychotic features might be given. As the literature suggests, minority males may be more likely to be diagnosed as schizophrenic rather than psychotically depressed. It is also possible that white, especially middle to upper-class, clients, circumvent the community mental health system and seek hospitalization when symptoms persist or are severe.

Further examination needs to be made of the impact of disadvantaged status on minority females and the likelihood of developing more severe symptoms of depression as a result. It would also be useful to examine the criteria that clinicians use in making a diagnosis to uncover whether or not that criteria differs for race and sex variables.

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Cross-Cultural Conflict between the Urban Provider and Rural Clients and Staff

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In mental health work, we are often reminded that one ought "to start where the client is." Experience suggests that this is not so easy to do As sensitive as we might try to be, culture runs deeper than our awareness in everyday life. The ways in which we move, talk, listen, dress, stand and sit are all symbols that are interpreted by others around us. Among urban professionals, there seems to be a broad consensus as to the meaning of gesture and symbols that form a part of "our world-taken-for-granted." The thesis presented here is that this consensus is not generally shared by rural people who live on the fringes of urban, mass culture. They retain distinctive world views and symbolic interpretations often not understood by the practitioner. It is my experience that the lack of common understanding among the urban professional and local staff and clients has effected service delivery programs in rural areas.

This paper reports the result of interviews and encounter sessions held with local and non-local staff of a health services program in Western North Carolina. Additional data have been generated from counseling and consulting in a skilled-care facilty and mental health center in rural Appalachian Western North Carolina.

My focus will be on different patterns of interaction and interpretation of symbols between practitioners and rural people. This emphasis does not consider problems of client expectations of services nor information about the area being served (Brownlee, 1978). Practitioners need awareness of how they and their services are perceived by client groups. A "good" dentist, for example, might be defined as a provider who pulls (not fills) teeth. A "good" doctor or therapist may be expected to give pills on the spot rather than advice about diet or a piece of paper to direct the client to get medicine elsewhere.

What is the significance of traditional medicines and practice in a particular locality? (Friedl, 1979:15). How did a community handle stress and misfortune prior to being served by social and mental health programs? What role does God play in community imagery and life? Practitioners who enter into a rural community without responses to these types of questions should expect some confusing and uncomfortable moments, which can limit their effectiveness.

Differing interpretations of interaction and symbol can be harmful. I have identified seven general problem areas in relations between rural people and practitioners who are acculturated to urban life and who come "from the outside." These areas are: 1) labeling, 2) orientations in interactions, 3) definitions of time, 4) approaches to problem-solving, 5) interpretations of change, and 6) the role of the sacred among significant others.

One prefatory note: A quick look at "Snuffy Smith" in the comics or at television programs or movies that deal with rural or small town themes gives an idea of how America looks at rural life and people. Rural clients know full

well that many of their fellow Americans see them in derisive, stereotypic terms, such as "hicks." A colleague suggests that this causes a "love-hate" relationship with urban things and people. It also tends to make the rural client wary of the urban practitioner.

LABELING: HOW DO PEOPLE REFER TO EACH OTHER?

A therapist calls to a client sitting in the lobby of a mental health center. "Mr. Johnson, would you . . . ." The client breaks in: "You know when you call me that I just don't feel like it's me." While that may be one way to start, I think the therapist had "muddied the water," making it more difficult to establish supportive rapport with the client.

Another example: Local people on a rural health program staff reacted strongly to an edict from consultants that it is "unprofessional" to relate to clients on a first name basis. One of the staff said during an interview:

> I can't call someone I've grown up with "mister." I see him all the time. We go to church together. If I call him "mister," when I got off work he'd say to me, "what's wrong with you? You gettin' a big head up there at the clinic?" I just can't do it.

In contrast, a woman physician from New England resented being called by her first name. She had seen male physicians use first names as a means of communicating to patients that the male was in charge in a specific situation. So, local people resented not using first names, and an urban practitioner resented using them. This cultural conflict led to angry looks and asides and stress in staff relations.

In small communities, individuals view themselves and others as having particular identities as opposed to seeing themselves as a group or category of people. These identities are given or ascribed. A rural client told me:

> Our preacher was going to go to school to study the Bible. But people in our community got real concerned that he might try to become a preacher, instead of being one . . . that learning about the word of God would stop him from hearing it, and he might not be called to God anymore.

Anthropologist Helen Lewis talks of asking the rural lad "Johnny" -- What do you plan to be when you grow up? His answer is "Johnny" (Lewis, 1971:6). He sees himself as a recognized individual within the group, with rights, duties, and obligations. What he may ultimately do for a living is secondary. His doing will never replace his being, that is as long as he lives in a place where everybody knows everybody. If, "Johnny" goes to graduate school in Chapel Hill and attends a party, the first question people will want answered is "what do you do?" Urban people determine who a person is by what a person does. As acculturation sets, "Johnny" will begin to define himself in that way.

ORIENTATIONS IN INTERACTION

This discussion is an extension of the previous point. In impersonal, urban social systems, structural anonymity requires us to continually present ourselves. Our legitimacy and status in the social system requires it. Urban people learn very early in life that they must expend considerable energy presenting themselves in the urban world. Legitimacy depends on achieved status. People make certain that others know that they are social workers, therapists, teachers, or graduate students. In rural social systems, status is not achieved by the individual, but ascribed by the community. Persons who seek recognition on the basis of achievement or position are often criticized for "forgettin' about their raisin'" (Matthews, 1966:75). The medical doctor, whose position in the community is based on achieved status, is an exception.

Microsociologists such as Georg Simmel and Erving Goffman have observed the ways in which people present themselves to obtain legitimacy and control in social situations. Such presentations require some skill in verbal communication. The communication is seen as "chatter" which is offensive in the rural cultural world where people who talk about themselves are seen as trying to stand out from, rather than fit into, the group (Hicks, 1976:90-91). Additionally, the chatter is symbolic of a skill and agility with words which many rural people find threatening. "They can out-talk you, and out-think you," one local informant said. A clinic receptionist told me, "The director is always talking in words that go over my head. Big, long words. With him you have to be very clever . . . you have to play at putting words together in various ways." Implied in such statements is the idea that insufficient cleverness leads to being vulnerable and manipulated. One informant complained:

> Why, they don't even know how to be quiet! If it's quiet before a meeting, Mr. G (an administrator) can't stand it. He gets real nervous.

Another said:

> You don't need to talk all the time. Why, you can plant a field and never say a word.

There is another danger in those chattering urban professionals from the perspective of a rural client: The professionals do not know how to listen. As a rural resident stated,

> They don't know how to listen to us. We know this area. We're from here. We know how people feel and what's going on.

A receptionist commented on doctors:

> They don't listen to the patients . . . they just ask questions but don't really listen . . . they make us feel like we just don't understand, or that whatever it is is our fault . . . .

The perception of not listening leads to an interpretation of assumed superiority on the part of the other party and the idea that the professional doesn't really care about the client. If these perceptions are in fact cross-cultural in interpretations (rather than the experience of relations with an uncaring provider), what can a provider do to correct them? She can pay more attention to what rural people focus on and discuss in everyday life. She also can reflect on how people listen to each other. What posture, for example, communicates, "Hey, I'm really listening to you?"

Traditions make common discussion topics among rural people. There are many traditional remedies for healing, and people like to talk about them even if they do not use them anymore. A practitioner who indicates she does not share an interest in "old time" cures or folkways is setting up a barrier between herself and the client:

> . . . the doctors should respect the home remedies people talk about . . . like lard and soda, or potatoes, or vinegar for burns. But they don't pay any attention to these things (and) patients just don't talk after a while . . .

Often, what the practitioner does talk about is seen as inappropriate:

> Then they ask you all these personal questions . . . about your family and all . . . .
>
> You just don't ask people personal questions about their family life. If people want to share something, they'll tell you.

How do you get a family history or a sense of what aspects of client's life might be related to a particular problem? I suggest the addage "You've got to start where the client is" and refer to Edward Hall's concept of "high context" and "low context" cultures. Hall argues that most urban Americans are low context, that is they get "right down to business." Efficiency is a hallmark of our culture, and therefore "we tend to put more emphasis on the verbal message and less on the context." Arabs, he suggests, are high-context people, in that their communications are set within the context of interpersonal relationships. If you do not take time to establish a relationship with a person, you cannot do business with them unless you do it on the basis of power. Power can be force, bribes or bureaucratic role definitions such as "case worker" (Hall, 1979: 45-54). If rural people are high-context people, the professional becomes more effective by relating to them in a context-developing manner.

Local informants suggested how this can be done.

> Doctors L and H are just like us. When they come to work, they stop and talk to each one of us. They talk to you like a friend.
>
> What do you talk about?

> Anything. He'll tell you how his water froze up last night . . . Just everyday things that we all know . . . the weather, families, feelings . . . .

The doctors indicate by their more highly contexted behavior that people come before business. This mode of relating to people has been described by Herbert Gans as person-orientation as opposed to object-orientation. "Object-oriented individualism involves striving towards the achievement of an object. . . . the overriding aspiration in person-oriented individualism is to be a person within the group" (Gans, 1962: 89-97).

In applying Gans's concept to rural West Virginians, Weller notes:

> . . . you just don't stop in for a moment to check on a detail or two of business, then move on. Each contact is a person-to-person encounter, and this takes time -- hours of it . . . .
>
> A county school official recently discussed his efforts to see three men who were being chosen for a special training program. It took him six hours because -- as he noted .. "you can't do business with these people on a time schedule." You must also "set a spell," and in the midst of this person-to-person meeting any business you may have can be done" (Weller, 1965: 55).

In sum, one gets needed information within the context of a broader social interaction. For the urban-oriented practitioner, it may seem silly to start by talking about the garden or the weather, but that may be the only way ultimately to get down to business. Starting with business invites ineffectiveness. A van driver's comments:

> When I drive somebody in to the clinic, often he's talked to me for about 20 minutes . . . Now, he doesn't talk with the doctor like that . . . I could tell the doctor a lot and help make the patient feel more comfortable if he (the doctor) would only listen.

In the Western North Carolina health clinic studied, rural staff members discussed the correct way for a person to come to work in the morning. A well-liked physician was reported to stop and talk with each staff member, from the van driver to the receptionist, sometimes taking 20 minutes to get to his office. By contrast, the "cold" doctor said "hello" to everybody, but "he didn't even break his stride" until he got to the drug cabinet before proceeding to patient records and finally to his office. This more object-oriented behavior, acceptable in an urban context, caused deep resentment among rural staff and clients which in turn limited provider effectivenss.

Posture was noticed. There has been much discussion about body language in recent years; posture is a symbol to be interpreted by others in any social situation. The preferred physican stood back on his hips, while the "cold doc" leaned forward. If the former walked into a wall, his stomach would have touched first; the latter's forehead would have had first contact. The "stomach-first"

posture, along with other body language such as firmly planted feet and absence of movement, was interpreted as meaning "he really listens to you." The "forehead first" posture was somehow disquieting. A walk about the community surrounding the clinic revealed that most men appeared to stand in a posture similar to the popular physician. An urban staff member who was a "forehead man" recalled that a frustrated client had once told him: "Buddy, I don't even like the way you walk."

Clothing is also symbolic. Rural people often identify denim and old clothes with farm work. I have a farmer neighbor who will not come in my house wearing overalls. When he has farm clothes on, we stand outside and talk. When he has his slacks and a shirt on, he comes inside. The words of rural staff members in the clinic suggest the attention given to clothing:

> I'm tired of apologizing for a doctor who "looks dirty."
>
> Old clothes say to the client "We don't think you're very important."
>
> The community asks us what we think about a new doctor. When a new doc comes in, people always call us . . . They ask
>
> "Is he clean?"
>
> "Is he hippy-looking?"

Cleanliness is associated with certain kinds of clothing. For example, when you are working around manure, you wear denim. Clothing can be symbolic of many other things such as wealth, the urban world, and sexuality. It is important to know how clothing is interpreted in a specific community.

Most urban-reared practitioners are object-oriented people entering a rural, person-oriented world. How they walk, talk, and dress appears to have an influence on their effectiveness. There may be a trade-off between effectiveness and individual choice, freedom, and identity, as one chooses to conform or not to conform to local norms and patterns of life. One agency director who describes himself as "a former hippie" said, "I never feel really comfortable in the clothes I come to work in."

DEFINITIONS OF TIME

In rural life, time is seasonal and natural. There are periods of the year which require 14-hour days of intense labor, and there are slack moments when a person can sit back a bit (Campbell, 1969: 61-73). To people brought up in rural environments, the idea that work activity is controlled by a clock seems somewhat artificial. For clients, the idea of punctuality for appointments is taken lightly. In keeping with a person-oriented value system, the appointments record appears to improve with direct contact with the care provider (Friedl, 1979: 18).

For rural staff, the idea that a clock, rather than work load, determines what you do, seems to be a source of resentment. One clinic secretary confided:

> I don't know. I guess I feel watched. Even the director feels he's being watched (although I feel he's watching me). I went into his office one day and he was reading Time magazine. He looked really embarrassed and dropped the magazine and said, "It looks like you caught me." Why can't he realize that I don't care. What's wrong with reading a magazine in a spare moment.

Her statement suggests something else about clocks. They are a behavioral control external to the process of group interaction that is central and normative in small communities.

APPROACHES TO PROBLEM SOLVING

Several years ago, an incident at a facility in Western North Carolina led to a grievance procedure which effected the agency director's rapport with his staff. He had instructed a van driver to cut the lawn, which had been previously cut by a teenager who increased his rates. The director thought it would be cheaper to buy a lawn mower and assign the task to an under-utilized van driver. There was no question that the van driver had the time for the task.

To the director accustomed to the process of decision-making through hierarchy, the request seemed routine. To the van driver, who gained the support of the entire rural staff, the request violated a basic rural value of equality and consensus in problem solving.

> Why, all he had to say was "George that grass is gettin' awful high. What do you think we might do about it?" I would have said, "Well, I'll take care of it."

The van driver won his grievance. Immediately after the hearing, he mowed the grass without being ordered to do so. He continued to do it; he had appropriated the job on his own.

Students of rural mountain communities emphasize the high value assigned to group solidarity and cohesion at the expense of individual differentiation and achievement. This is not in contradiction with the earlier statements about "Johnny." In a cultural milieu which emphasizes being rather than doing, Johnny is still Johnny the individual. His individuality is seen within the overall context of the group and on an ethic of equality and cooperation (Hicks, 1976: 88-91; Matthews, 1966: 74-84). Social systems with the vertical lines of authority such as a mental health clinic are in contrast to the norms of horizontal relations in group-oriented rural systems. The conflict between vertical and horizontal systems can cause anger, distrust, and refusal to cooperate among rural clients and staff. A clinic secretary said, "A neighbor of mine said she wouldn't take her medicine unless I said it was 'okay.'" A van driver reported:

> A woman called me last Saturday night and asked if she should take her husband on to the hospital. He was bad off and was supposed to go in on Monday. I asked her if she had called our (doctor on call at the emergency weekend)

> number. She said, "no!" She said that she "could never get anything out of them anyhow" and that she trusted my opinion. So I told her to take him on in. She did.

The rural ethic of equality that underlies an emphasis on horizontal relations requires cordiality and information-sharing different from an agency's hierarchal rules of conduct. Some examples are:

> When somebody comes in (to the clinic) I'm not supposed to (make small) talk to them. But what are they going to think? They're going to say, "what's happened to her?"

> When a patient asks what his blood pressure is, we aren't supposed to say anything. Then they think something is really wrong. (Then) they get scared . . . nervous.

The withholding of information stratifies an interaction. People with data can control the situation, people without data are made vulnerable by their ignorance. A potential result of a hierarchal control of information is for the client to have feelings of powerlessness and resentment.

Among agency staff, unequal relations results in the feeling that urban professionals do not respect and do not trust their rural co-workers:

> He just doesn't seem to trust me. It's funny though, with some things he does . . . all that money coming in and I account for it. He trusts me with the books . . . but not with a key to the office.

> He trusts me in my job, but not as a person . . . I can't just talk to X (the agency director). I have to follow the chain of command.

> They're always checking on us. Why don't they trust us?

Obviously, these feelings complicate an agency's operation and effectiveness. The hierarchical approach to problem solving and task completion is often dysfunctional in the rural setting. Special sensitivity and creativity on the part of supervisory staff is required.

Interpretations of Change

A woman, who had recently moved to a rural community, expressed frustration over the fact that local women on an agency staff seemed to isolate her in the work environment. One of the local women responded:

> Well, I guest your little boy is just about the same age as mine. Every Sunday we walk down the road together and to to church just like I did when I was a little girl. And when he grows up, I want him to be walking down that road to that church.

> But you . . . people like you come in here and change everything. And I don't want things to change. I don't want change . . . I want things to stay as they are . . . .

Since the mid-19th century, an urban, industrial America has defined change as progress. In mainstream culture, progress is such a deeply imbued value. The history of change in rural Appalachia is that destruction of family and community life and of impoverishment of a region and its people (Eller,) 1982; Gaventa, 1980)· History has taught many rural people to fear change. Additionally, at the cultural level, agricultural societies tend to value balance and a cyclical sense of renewal over linear change (Diamond, 1974; 206-207). The value conflict between balance and progress is a source of client and staff anxiety. It is rooted in historical reality and cultural norms. Urban staff members might examine their assumptions about progress and the idea that change always means improvement.

THE ROLE OF THE SACRED AMONG SIGNIFICANT OTHERS

"Oh, God!" she said, as spilled coffee seeped into her dress. It certainly was not a prayerful statement, but God was not real to the urban person in this case. To many rural people, however, God is as real as the chair on which you sit.

W. I. Thomas said, "If people define situations as real, they are real in their consequences." God is real and Christ as God Incarnate is real to many people (James, 1982: 69-77). There are significant others to whom many rural people turn in determining right and wrong (Cole, 1971: 578-617). I gave a questionnaire to urban professional and local nonprofessional staff asking, "What persons or figures do you think of as being important to you in the evaluation of your actions?" The professionals answered "family, friends, and peers." A significant number of rural staff started their lists with "God." If God is a concrete and personal experience, then yelling at God over a spilled cup of coffee is inappropriate. With change comes secularization and the denial of God, but in rural areas, a strong sense of the sacred exists.

Those who have counseled rural clients know the power of the sacred. Some clients have endured overwhelming crises of abuse, neglect, and poverty and say, "I couldn't have survived without the strength of God." At the other end the continuum is the psychotic crying to the therapist, "I'm falling, I'm falling into Hell . . . . I can see the flames. Oh help me, I'm falling . . . ."

The therapist said, "Can you see your feet? Can you see your feet on the floor?"

> "Yes." replied the client.
>
> "See, the floor is solid. You're not falling . . .," the therapist spoke.

Starting "Where the client is," the therapist sought to redefine the situation by redefining reality for the psychotic client through a process of shared perceptions of an ongoing experience. In this case, the sharing process did relieve momentarily the hallucinatory crisis.

More research needs to be directed to uncovering the role of spiritual life and symbols in the mind and lives of rural people. Most therapists seem to be uncomfortable in this area, holding the rural cultures' definitions of the sacred at a distance and primarily in ridicule. By doing this, they may be denying themselves and their clients a valuable resources for healing. It is necessary to examine beliefs and symbols common to rural culture that can aid the development of appropriate adjustment mechanisms and good mental health.

For the present, however, therapists must be prepared to answer some very specific and often asked questions from both rural staff and clients:

> Are you a Christian? Do you know Christ as your personal savior? Where do you go to church? Do you workship Satan? Are you married?

Beyond these questions lie the moral rules of religious fundamentalism which contradict the relativity found in mental health work. These are rules that can give a simple "no" to seemingly complex issues such as divorce, abortion, premarital sex and equality of women.

If practitioners in rural areas are going to be more than the secular "missionaries" of an advancing urban cultural system, they will have to learn to serve clients amid the signs, symbols and mores of their own cultural worlds.

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Admission Patterns of Blacks in Community Mental Health Centers and Comprehensive Health/Mental Health Centers

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INTRODUCTION

The problem of underutilization of outpatient mental health services by blacks has been addressed in the literature. The problem takes many forms, including high drop-out rates, avoidance of services, inadequate services, and inappropriate diagnosis and treatment. Jourard and Lasakow (1958) found that 75 percent of lower income blacks and 38 percent of middle income blacks with one experience with mental health services stated that they would not return. None of the white clients held such an opinion.

Several studies have focused on utilization rates and correlation of those rates with demographic characteristics, personality, social, and cultural profiles. Other studies have investigated differences in services, diagnosis, and treatment. Windle (1980) has suggested that since the goal and mission of local community mental health centers is to provide services in proportion to unmet needs, then blacks should utilize mental health centers in higher proportion than whites. He notes epidemologic studies by Dohrenwend and Dohrenwend (1969), indicating that low socioeconomic status is strongly associated with higher prevalence of mental health problems, and that race is highly related to socioeconomic status.

Previous work by this author examined factors contributing to underutilization of mental health services by blacks in the Chapel Hill-Carrboro area (1982). Results of this study showed that in fiscal year 1980, the Orange-Person-Chatham Mental Health Center in Chapel Hill, North Carolina reported a 12 percent utilization of adult psychotherapy services by blacks, yet the percentage of blacks in this area is 25 percent. A greater proportion of blacks use other agency services such as developmental disabilities services, children's services, and substance abuse programs. These programs, because of the nature of the problem and the need for certain intervention, are generally not chosen freely by the individual. Clients for these services are more often referred to treatment by the courts. Goodman and Siegal (1971) found that blacks were admitted in higher proportion to special projects such as drug abuse programs, while whites showed a higher admission to outpatient psychotherapy services. Perceived reasons for minority underutilization of such outpatient services cited by local groups, agencies, and individuals interviewed in the 1982 study were:

1. People fear being labeled "crazy" if they go to mental health centers.

2. White clinicians need a better understanding of the black culture, in order to treat black clients.

3. Clinicians need to be more flexible with their treatment approaches and include advocacy roles.

4. Clinicians need to focus on practical solutions more, rather than intra-psychic conflicts.

5. Mental health centers need to make their services more accessible by providing transportation, shortening the waiting list, providing more evening hours, and making home visits.

6. Mental health centers need to increase their attention to variables that make black clients feel more comfortable receiving services, such as hiring more black therapists, providing more education to clients about the therapy process, etc.

7. Mental health centers need to establish closer ties with other human service agencies to facilitate appropriate referrals.

The 1982 study suggested that two comprehensive medical/mental health programs in the area did not observe a problem with underutilization of mental health/social work services by blacks. One of the programs, Orange-Chatham Comprehensive Health Services (serving the same areas as the designated mental health center) reports a 50 percent utilization rate of social work/mental health services by blacks. The other service program, Lincoln Community Health Center in Durham, North Carolina, believed their success with attracting blacks was due to "making services stigma-free and convenient" (Thornton and Carter, 1975). Staff from both programs suggested that social work/mental health services provided within a setting which meets all the health needs of the client would increase utilization of mental health services (Thornton, 1982; Maddox, 1982).

Papers have been written about the advantages of comprehensive medical/mental health programs. Many benefits have been suggested by authors, including the use of paraprofessionals of similar race to the client, early case findings, expedient referrals, cost effectiveness of collaborative services, non-separation of problems, and less stigmatized environment. For example, Dawkins (1978) in a study of post-hospitalization patients in a low-income black neighborhood found a high utilization of multi-discipline programs by blacks. Between 1975 and 1977, admissions increased from 131 black patients to 400. Borus (1976) reports that 20-70% of primary physicians' time is spent evaluating and treating emotional problems of patients, and that 48% of all referrals to the mental health component of medical settings were of patients first seen by general medical staff. The literature suggests that non-separation of problems is a belief of comprehensive care professionals, as well as the view of the clients. There may be an important difference in the philosophies of the two types of service agencies which may account for differences in utilization rates. Thornton (1982) suggests that black clients do not separate physical and mental health. The program described by Dawkins and Dawkins (1978) included vocational counseling, rehabilitation services, socialization programs, art therapy, recreation, and interest groups. Dawkins reported that the success of this multi-disciplinary approach was due to focusing more attention on the life-function needs of the individual rather than on the mental disorder. Borus (1976), Lowenkopf and Zwerling (1971), and Scherl and

English (1969) suggest that blacks are more amenable to working on practical, concrete problems. Gullate (1972) addresses the stigma attached to mental health treatment when she discusses the hazards of "separating responsibilities into provinces." She believes,

> Mental health programs must be judiciously woven into the fabric of community health programs. In this manner no illness is looked upon as being so radically different that special isolation is necessary . . . adding a negative stigma to it. (p. 136)

Clients frequently have fears about mental illness and psychotherapy. Non-mental health professionals have engaged the client may be able to make a referral for psychotherapy more acceptable to the client. Additionally, the efficiency of the referral prevents or decreases the possibility of clients getting "cold feet."

The current study examines further the differences between community mental health centers and comprehensive medical/mental health programs, and examines black utilization of these types of services. The Orange-Person-Chatham Mental Health Center and the Orange-Chatham Comprehensive Health Center are compared in this paper. Data on admissions to both types of clinics have been gathered, and interviews with staff members from the comprehensive program and the mental health programs have been conducted. This study was designed to answer the following questions:

1. Is the low utilization of community mental health services by blacks related to a cultural lack of "psychological mindedness" and negative feelings about the efficacy of psychotherapy?

2. Do medical/mental health settings act as buffers to make treatment for psychological or psychosomatic problems more acceptable to blacks?

3. Are referrals for mental health treatment within a multi-discipline agency more likely to be followed by blacks than a referral to a mental health center?

METHODS

Data were collected from the Orange-Person-Chatham Mental Health Center's (OPC-MHC) clinics in Chapel Hill and in Pittsboro, North Carolina. Also data were used from the clinics of the Orange-Chatham Comprehensive Health Services (OCCHS) in the same towns. The Chapel Hill-Carrboro area has a population of 39,757. The racial composition of that area is 13 percent blacks and 85 percent white. The Pittsboro area consists of a population of 1,372 and the racial composition is 24 percent black and 76 percent white.

OPC-MHC is a community mental halth center that provides the following services: outpatient psychotherapy to adults and children; day treatment services to adults and children; services to the mentally, physically, and emotionally handicapped; alcohol and drug services; and a 24 hour emergency service.

OCCHS is a non-profit corporation funded by the Department of Health and Human Services. The center offers primary medical care, preventive health care, diagnostic x-ray and laboratory services, dental care, mental health services, pharmaceutical services, social services, nutritional services, transporation assistance, optometry services, and the Women-Infant-and Children food program. This agency accepts Medicare, Medicaid, and other health insurance payment. Payment for services is determined according to a sliding scale fee schedule.

Data were abstracted from the records of all four clinics participating in this study. Records on admissions were reviewed for the calendar year of 1982 for OPC-MHC and for six months of that year for OCHHS. Data were gathered only on adults (ages 18-over). Admission information was collected on those clients needing either crisis, short term or long term individual psychotherapy. In addition to the review of records, interviews were held with staff members at OPC-MHC and with the social work/mental health staff person at OCCHS. These interviews were to discuss presenting problems of clients, types of services offered, staff impressions about the referral system within the agency.

RESULTS AND DISCUSSION

Thirteen blacks were seen in the Chapel Hill-Carrboro OPC clinic during 1982. This is eight percent of all such admissions. The corresponding figure for the same catchment area of OCCHS between October 1982 and March 1983 is 15. This represents 37 percent of all admissions to adult psychotherapy. The Pittsboro clinic of OPC admitted ten blacks during that one year period. This is 26 percent of all admissions. The OCCHS clinic in Pittsboro admitted 32 blacks. This represents a 63 percent utilization of all services. These findings indicate that under-utilization of services by blacks is not experienced at the same level in the comprehensive health care program as it is in the mental health centers in the same area. It also appears that the more rural the area (Pittsboro), the better the utilization of mental health services by blacks.

REFERRALS

The staff at the OCCHS report that 73-80 percent of all referrals come from within the agency. Referrals come from all components of the agency including medical professionals, nutritionist, and support staff. Other studies have found that a significant percentage of referrals to mental health departments in medical settings are from other disciplines (Brous, 1976; Prindaville, et. al., 1983; and Thornton and Carter, 1975).

The observation by OCCHS staff sugggests strongly that having several services in the same building increases the opportunity of offering efficient, responsive services for the total care of the patient. Additionally, it speaks to the collaborative spirit of professionals. These observations suggest that through the efficiency of the referral process, fewer patients are lost and more comply with treatment.

NON-SEPARATION OF PHYSICAL AND MENTAL HEALTH

Social work/mental health staff in the OCCHS program report that a great many presenting problems of clients, reported either to the medical or the mental health staff, are not linked to psychological or emotional issues. Clients' problems are initially presented as environmental (other systems), financial, medical, or family related. Staff report that probing into initial problems invariably reveals a mental health problem needing mental health intervention. OPC-MHC staff, in discussing their black clients presenting problems, concur with the above observation. These comments support Thornton and Carter (1975) assertion that "Physical and social realities of poverty and racism are not without psychic consequences." As well as Scherl's (1969) statement that "Mental health should address the outer realities as well as the inner realities ..(because) mental health is less valued than money, food, housing." When such practical day-to-day problems arise, the client may willing to accept help focused on those areas. They may then be more amenable to examining the relationship of environmental and social problems to psychological problems. Concerning the issue of non-separation of problems, staff form the OCCHS clinics suggest that blacks prefer to work on practical, day-to-day problems.

OCCHS staff report that many clients present saying "I have nerve problems," or It's my nerves." Occasionally this presentation is compiled with a request for tranquilizers. Further exploration reveals that "nerves" is defined by the client as depression, anxiety, overwhelming stress, crying a lot, etc. This observation may suggest that black clients do not customarily think in psychological or emotional terms.

FEAR OF STIGMA ATTACHED TO MENTAL HEALTH TREATMENT

Other OCCHS comments note the great trepidation of clients about coming for psychotherapy. Clients' comments suggest that the therapy process is frightening. This fear probably reflects the stigma attached to mental illness. Apparently clients fear that entering treatment may mean they are "crazy." The social work staff describe the importance of client education about common emotional and mental health needs as well as types of treatment and treatment process. Comments from clients have frequently made reference to what happened to someone with an extremely serious disturbance. These comments are then related to clients' current situation. These OCCHS observations are similar to the author's findings that the stigma issue surfaced often as a contributor to underutilization of mental health services by blacks (Harris, 1982). Borus reports similar findings (1976).

IMPLICATIONS AND CONCLUSIONS

The finding that the OCCHS clinics in Orange and Chatham counties experienced more success with admitting blacks than the OPC-MHC clinics in those counties was based on admission data. Retention and readmission rates would provide more detail on utilization patterns and will be addressed in future work.

The OCCHS staff observed several advantages of a comprehensive medical/mental health system. These are 1. psychosomatic and psychological problems are often discovered by the primary health provider, 2. the referrals for mental health treatment are more efficiently made than when referring the client to another agency, 3. the collaborative and consultative relationship of the disciplines increases the likelihood of better patient care, 4. the social work/mental health unit is seen as valuable and is utilized of by other professionals, and 5. the philosophy of non-separation of problems held by professionals increases the clients acceptance of all services available in the comprehensive program. The structure and setting of comprehensive programs appears to facilitate the flexible, less traditional approach to treatment. Thornton and Carter (1975) reported "Mental health centers are generally not equipped to offer the many needed services, neither are they in a position adequately to coordinate these services even if available."

The approach needed to serve people from low-socioeconomic groups is reminscent of the psychosocial framework basic to social work practice. This person-in-situation theory (Hollis, 1972; Turner, 1978) centers around "The psychological man and his social system functioning as a product of interactions among biogenetic endowment, effects of significant relationships and events, impacts of life experiences, and participation in societal, cultural, and current events." Many mental health clinicians would say that they approach the treatment of their clients by considering the total person. However, the structure of most community mental health centers does not facilitate meeting all the service needs of the client or viewing them interdependently. Many mental health centers, with their emphasis solely on psychological services, make it almost impossible to treat clients comprehensively. Clinical social workers in these settings may find it difficult to avoid assimilation into this traditionally singular approach to treatment.

This study primarily compared the structure of the two agencies as related to admission of blacks to treatment. There may exist other factors that contribute to the high utilization of comprehensive services by blacks, such as racial composition of staff and accessibility. The proportion of black professional staff is higher at OCCHS than at OPC-MHC. OCCHS provides transportation and home visits, OPC-MHC does not provide these services.

Although the cases seen by the mental health/social work staff at OCCHS are appropriate for mental health intervention, some referrals are made to OPC-MHC. The criteria for referrals to OPC-MHC are not clear. However, it appears that more serious problems necessitating psychotropic mediation are referred because OCCHS does not have a staff psychiatrist.

The results of this study or any findings about the benefits of comprehensive programs do not imply that mental health centers are failing, or that mental health centers should completely overhaul their programs to attract the black population. Certainly some factors that prevent blacks from utilizing services of mental health centers should be investigated and ameliorated. Increasing black professional staff, making services more convenient and accessible (such as evening clinics and transportation services), improving relationships with other agenices to increase referrals, and providing more community outreach through education about mental or emotional illness are crucial to the success of mental health centers in attracting more blacks.

Although the structure of traditional mental health setting does not provide for the direct care of all the clients' needs, clinicians awareness and adoption of the interdependence of problems can be useful in making appropriate referrals to other agencies.

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The Influence of Rural Social Networks Upon the Perception and Utilization of Community Mental Health Services

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INTRODUCTION

Our study explores the perception rural people have of community mental health services from a social network point of view. In other words, do rural persons see the mental health center as part of an exchange network? If so, how do they use the center? What linkages exist between their problems and mental health services? To begin to answer these questions, one must study how exchanges take place between people in regard to mental health needs.

The study of social support is primarily an investigation of the manner in which human attachments are organized into systems that exchange affective resources. The exchange operates to exercise constraints as well as to provide support, for example, by reducing stress and increasing coping abilities (Gore, 1980; Laumann, 1973; Hirsch, 1979). The structure of such an exchange system is what we have termed a social network. Social networks have been found to be both diverse and ubiquitous in communities (Wellman, 1979). Major attention has been focused upon the need to identify and involve social networks in any comprehensive plan to address an area's mental health needs. (Gottlieb, 1981; Froland, 1980). There are, in fact, many difficulties in accomplishing this task. A number of these difficulties are methodological and relate to the problems attendent upon conducting network analysis (Holland, 1979; Wolfe, 1978). For example, one study like ours began by attempting to identify patterns of help seeking through the use of a community survey (D'Augelli, 1981). This approach has been criticized as inadequate for the purpose of network analysis (Gottlieb, 1981). However, our use of the survey technique had less ambitious and more limited goals. Our survey research had the goal of sampling norms of local social networks concerning the perception and use of natural or organizational helpers. Our intent was to compare survey data with the program strategies which the community mental health center staff believe are being used to link the center with local social networks.

THE RURAL SOCIAL NETWORK

A number of important studies of social networks have focused upon the relationship between stress and dimensions of urban life (Duhl, 1963; Cohen & Sokolvsky, 1978). Perhaps the classic work in this area is that of John Cassel (1974). Cassel argues that environmental disorganization led to ill health because of the lack of social feedback. He advised that improve-

ment and strengthening of social support was the practical direction for prevention. Cassel did not consider that many of the described aversive elements of the environment exist in rural areas. Inadequate and crowded housing of poor people occurs in rural as well as urban areas. In our catchment area, some neighborhoods are deteriorating and the landscape is dotted with tenant shacks. Only recently in Pitt County has the incidence of infant mortality and tuberculosis declined. Both rates are uncommonly high (See ECHSA Plan, 1981). It seems that Cassel's observations are applicable to rural areas. Therefore, we expect that a relationship between social support and mental health may exist in rural areas.

The rural social network has been described by Louise Johnson (1980) as one with four components: 1) personal; 2) natural; 3) formal; and 4) organizational. The natural network includes family, friends, extended family, natural helpers, volunteers, "benefits", and self help groups. This network often has no linkage with more formal networks which include ministers and physicians. While the social worker may feel comfortable with the formal network, the social worker is a part of the organizational network. The organizational network often operates without awareness, understanding, or communication with other networks. When this is true, the concept of linking has special importance in the rural environment.

Linkage refers to the process by which a person(s) with specific needs is connected with a resource in a manner that permits the development of a helping system. Caplan (1974) outlined activities that community mental health centers could initiate to develop connections to other networks. These ideas have specifically been developed in a manner which can extend to the rural situation by Froland, Pancoast, Chapman, and Kimboko (1981).

LINKAGES AND PROGRAM STRATEGIES

There are a number of difficulties which must be faced in the task of linking natural, formal, and organizational systems. Our research focuses upon the description of staff perceptions of those linkages and the program strategies mounted to achieve them. This is a topic central to the Froland model. The model has three parts: 1) linkage opportunities; 2) staff role definition; and 3) program strategies.

The problems the agency wishes to address usually lead staff to define opportunities for developing linkages. For example, if the problem focus were health-related issues and the target population were mental health clients, then the staff might develop linkages through patient medication support groups.

The roles staff take are influenced by a number of variables. For example, close supervision or monitoring of helpers' activities by professionals indicates a decision to retain authority. If helpers are encouraged to participate in activity definition, then there is a willingness to share authority. There are three different types of relationships underlying the linkages identified by Froland. These were termed coordinative, collegial, and directive. The coordinative relationship implies a high degree of independent action by the helpers. The collegial relationship is characterized by interdependence. The directive relationship restricts the responsibility

and authority accorded informal helpers. Staff role definitions lead naturally to program strategies, the third part of the model. It is through the program strategy that one can identify which social network is to be involved and who are the appropriate informal helper.

The first program strategy is concerned with identifying the personal support network of that individual. This strategy focuses upon the informal efforts of family, friends and neighbors. Agency staff establish a relationship with these informal helpers in order to sustain and reinforce their efforts. Linkage occurs as the staff act as resources in the development and maintenance of the helping personal support network.

The second program strategy is a volunteer linking network. The staff works to develop one-to-one relationships between persons in need of support or advocacy and informal helpers who could successfully provide advice, support, and personal commitment.

The third program strategy attempts to establish a mutual aid network. Staffwork in this strategy is to bring together, sets of individuals who have experienced similar problems, encountered common obstacles, or shared interests. In this strategy, staff may attempt to involve themselves with existing mutual aid groups. They may work to create mutual aid networks for support or organize a mutual aid network for advocacy. Staff linkages may include developing a working relationship with key figures within the network and providing advice, consultation, or assistance in obtaining resources. While this strategy offers a number of advantages, there are serious difficulties, such as member conflicts or leadership cliques.

A neighborhood helping network is the fourth program strategy. This strategy directs staff to identify natural helping networks in the context of a geographically defined community. Staff work with helpers in assisting isolated persons, promoting mutual aid, identifying local issues, and strengthening informal neighborhood organization. The goal is to understand and link natural helpers, special skills, and local concerns.

The fifth program strategy is a community improvement network. This network is developed in the same manner as the neighborhood network with a different goal. The goal is political in that the staff develops a forum for informal leaders who represent a range of informal interest groups. The leaders become visible, vocal, and exercise political skills and resources. By articulating service needs, such leaders help the community feel ownership of developing services.

METHODOLOGY

A survey instrument was constructed to sample the norms of local social networks. The focus of the one-page check list survey was to solicit information about which natural, formal, or organizational helpers to which the respondent might turn to when in difficulty. The survey also probed their knowledge of the mental health center and its services.

The survey was administered during the months of October and November, 1982. The surveyors were students from an introductory social work class at East Carolina University. The student volunteers were oriented to the mental health center and its services, and the program evaluator explained the use of the survey instrument.

The survey sites were systematically selected by the mental health center to include major target population areas. Three hundred and twelve surveys were completed at six different places in Pitt County.

The second instrument was administered by the program evaluator. The instrument was a self-report checklist of the types of program strategies that program directors believed they used to link the center with local social networks. The program strategies listed were identified by Froland et al. (1981)

RESULTS

Data from each survey checklist were tabulated according to demographic and geographic factors to illustrate the knowledge and preferences of various population sub-groups.

Tables I and II summarize responses by age, sex and race.

According to Tables I and II, knowledge of the existence of a mental health center is greater among Black females in all age groups and White males in all age groups. White males and Black females in the 18-64 group, the over 64 group with the exception of Black males and Black females under 18 were all more likely to know where the Center was located than their counterparts. Black and White females over 64 were most likely to know someone who has utilized the center. Negative responses were greater among Black males over 64 than any other group.

Location--Table III illustrates responses according to the geographic location of the survey. Pitt County Mental Health Center offers services through the main clinic in Greenville, a satellite clinic in Farmville, and part-time clinics in Ayden and Bethel. The Pitt County Mental Health Center does not operate a clinic on the East Carolina University campus. Respondents from Bethel, Farmville, and Ayden were most apt to know of the Center's location, with Greenville and Ayden residents more likely to know someone utilizing center services. Respondents from Bethel were least likely to recommend center services.

Choice of Linkage--Responses were categorized according to social network helper preferences in Tables IV and V.

Respondents from Greenville, Bethel, Farmville, and Ayden expressed greater preference for formal networks; however, formal networks were notable in their responses. Organizational networks seemed to figure least in respondents' search for help. However, other survey findings indicate that the overwhelming majority (82%) of the respondents would go to the mental health center upon the recommendation of a significant other.

Visual inspection of the Tables show that there appears to be little difference between Black and White respondents in helper preferences. The greatest percentage difference occurs in White respondents over age 64. Those persons would seem to rely more upon organizational networks and much less on natural networks than other age and racial groups.

Linking Strategies--Table VI illustrates those program strategies which Pitt County Mental Health Center staff describe themselves as using to link with community social networks. It is interesting to note that the greatest number of referrals to the center come from natural sources, such as family, friends, self. Yet, direct linkages to the informal community by center staff are rather few and selective. The total network linking the center to natural helping networks seems to use the formal network as the "middleman." This may occur because of economic and time-efficiency. A staff member can link to formal networks with less effort expended than linking to natural networks at the neighborhood level. Staff linkage to formal networks may avoid the cultural conflict between organizational and natural helping networks. (Gottlieb, 1981)

Conflicts between the formal and organizational networks may exist. Once a person has chosen a minister or physician, they are not likely to be referred to a public facility, if they can afford private services. This is demonstrated in Table VII. Therefore, the Mental Health Center is more likely to serve people from lower socio-economic groups despite the linking program strategies in use. This highlights a potential future problem of the independent revenue generating abilities of Mental Health Centers.

In summary, it appears that rural persons view the mental health center as a part of an exchange network only when they are advised to do so by natural or formal networks. They are more likely to use the services when they do not have the ability to pay providers in the formal network or when the natural network cannot provide support. Current program strategies in the mental health center studied resflects this arrangement.

Linking tends to be through formal networks comprised of volunteers and professionals and through personal support networks composed of parents and patients. The Mental Health Association, Association for Retarded Citizens, Parent's Anonomous, and the Transition Home are examples of linking through mutual aid networks. Linking with impetus originiating at formal governmental levels include Willie M. and the Employee Assistance Program. Personal support linkages include the Mental Health Studies for local ministers, and the Pre-School Enrichment Program.

DISCUSSION

Without comparative data, it is impossible to know whether the program strategies used by the Pitt County Mental Health Center have influenced the social networks in its catchment area differently than any other Center. The best related data would be utilization rates and patterns of referral sources, compared with other centers in the Eastern Region of the state.

Pitt County Mental Health Center had the second highest admission rate (FY 1981-82) of the 13 Regional Centers in spite of numerous professional services available within the community due to the presence of a major university, a medical school and regional medical facilities. The center had a higher admission rate than the state average (1,577 per 100,000). Factors influencing greater utilization may include visibility of center services, proximity to other medical services, and an effective social network of referral sources.

Referral sources to the center can be categorized to organizational, formal and natural.

It is interesting to note that the greatest number of referrals to the center come from natural sources, such as family, friends, self as noted in Table VIII. Yet, direct linkages to the informal community by center staff are rather few and selective. The total network linking the center to natural helping networks seems to use the formal network as the "middleman." This may occur because of economy and time-efficency. A staff member can link to formal networks with less effort expending than linking to natural networks at the neighborhood level. Staff linkage to formal networks may avoid the cultural conflict between organizational and natural helping networks (Gottlieb, 1981).

Conflicts between the formal and organizational networks may exist. Once a person has chosen a minister or physician, they are not likely to be referred to a public facility, if they can afford private services. This is demonstrated in Table VII. Therefore, the mental health center is more likely to serve people from lower socio-economic groups despite the linking program strategies in use. This highlights a potential future of the independent revenue generating abilities of mental health centers.

In summary, it appears that rural persons view the mental health center as a part of an exchange network only when they are advised to do so by natural or formal networks. They are more likely to use the services when they do not have the ability to pay providers in the formal network or when the natural network cannot provide support. Current porgram strategies in the mental health center studied reflects this arrangement.

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TABLE I

BLACK RESPONDENTS (N=99)

Age	Sex	Is There a Center? Yes	No	Don't Know	Where? Yes	Know Anyone Who Used It? Yes	No	Encourage a Friends Yes	No	Not Sure
Under 18	Male	1	3	1	0	0	1	1	0	0
	Female	4	2	1	4	2	2	3	0	1
18-64	Male	12	8	10	8	2	6	7	1	0
	Female	36	3	6	26	7	19	23	1	2
Over 64	Male	3	2	2	2	2	0	2	0	0
	Female	5	0	0	5	5	0	4	0	1
Total		61	18	20	45	18	28	40	2	4
Percent		61.6	18.2	20.2	73.8	35.0[1]	65.0[1]	83.6[1]	3.3	13.1[1]

[1]Adjusted for missing data.

TABLE II

WHITE RESPONDENTS (N=189)

Age	Sex	Is There a Center? Yes	No	Don't Know	Where? Yes	Know Anyone Who Used It? Yes	No	Encourage a Friends Yes	No	Not Sure
Under 18	Male	3	4	2	1	0	1	1	0	0
	Female	3	3	3	3	2	1	3	0	0
18-64	Male	50	10	16	41	15	26	35	2	4
	Female	52	11	15	29	8	21	26	0	2
Over 64	Male	6	0	0	5	3	2	3	1	1
	Female	8	1	1	6	3	3	4	0	2
Total		122	29	37	85	31	54	71	3	9
Percent		64.5	18.3	20.1[1]	69.7	28.7[1]	71.3[1]	84.2[1]	2.5	13.3[1]

[1]Adjusted for missing data.

TABLE III

Location	Total	Is There a Center? Yes (%)	No	Don't Know	Where? Yes (%)	Know Anyone Who Used It? Yes	No	Encourage a Friends Yes	No	Not Sure
Greenville	119	81 (68)	16	22	52 (44)	25	27	43	1	8
Bethel	59	45 (76)	13	1	35 (59)	11	24	30	3	2
Farmville	34	23 (68)	4	7	19 (56)	7	13	16	1	2
ECU	79	35 (44)	10	34	19 (24)	3	16	16	0	3
Ayden	20	12 (60)	8	0	11 (55)	6	5	11	0	0
Total	311	196 (63)	51	64	136 (44)	52	85	116	5	15

TABLE IV

Location	Organized No.	Organized %	Formal No.	Formal %	Natural No.	Natural %	[1]Total Response
Greenville	46	26.6	73	42.2	54	31.2	173
Bethel	20	33.3	31	51.7	9	15.0	60
Farmville	2	4.8	21	50.0	19	45.2	42
ECU	18	15.9	43	38.1	52	46.0	113
Ayden	7	29.2	15	62.5	2	8.3	24
Total	93	22.6	183	44.4	136	33.0	412

[1]May reflect multiple responses for each respondent.

TABLE V

Race	Age	Organized No.	Organized %	Formal No.	Formal %	Natural No.	Natural %	[1]Total Response
White	Under 18	5	21.7	10	43.5	8	34.8	23
	18-64	38	20.2	84	44.7	66	35.1	188
	Over 64	8	36.4	10	44.5	4	18.2	22
[1]Total		51	21.9	104	44.6	78	33.5	233
Black	Under 18	4	26.7	6	40.0	5	33.3	15
	18-64	27	24.1	50	44.6	35	31.3	112
	Over 64	5	25.0	9	45.0	6	30.0	20
[1]Total		36	24.5	65	44.2	46	31.3	147

[1]Represents multiple responses

TABLE VIa

A TYPOLOGY OF PROGRAM STRATEGIES AS UTILIZED AT PITT COUNTY MENTAL HEALTH, MENTAL RETARDATION, SUBSTANCE ABUSE CENTER

Strategies	Objectives	Informal Helping Networks
Personal network	consult with client's significant others; support existing efforts	family members, friends, neighbors service providers
	convene network of providers & family, friends & others to resolve problems	
	expand client's range of social ties	
Volunteer linking	provide lay therapists for counseling	citizen volunteers
	estab. companionate relationship	people with skills, interests relevant to client's needs
	recruit & link volunteer advocates to clients	people with similar experiences
Mutual aid network	estab. peer support grps.	local church associates
	consult with existing groups & support activities	clients with similar problems; people with similar concerns
Neighborhood helpers	estab. consultative arrangement with neighbors to monitor problems	neighbors
		clerks, managers in local businesses
	convene neighbors to promote local helping	religious leaders
Community empowerment	estab. local task forces for meeting community needs	opinion leaders in local business, religious institutions
	provide for community forums to have input into local policies	members of local voluntary associations
		neighborhood leaders

TABLE VIb

A TYPOLOGY OF PROGRAM STRATEGIES AS UTILIZED AT PITT COUNTY MENTAL HEALTH, MENTAL RETARDATION, SUBSTANCE ABUSE CENTER

	PCMHC Services											
Strategies	C & E	M R	ADULT	CHILD	AL & DR	AFTER	CARE	AGERIA	PH	FAMVR	SALT E	ADMIN	Relationship
Personal network		X		X					X	X			Collegial
Volunteer linking	X												Directive
Mutual aid network	X	X		X	X			X	X	X			Collegial Directive or Coordinative
Neighborhood helpers	X												Collegial or Coordinative
Community empowerment		X								X		X	Coordinative

TABLE VII

Type Admission	PCMHC Ref. Sources Number	Percent	State Aug. (%) Referral Sources	Survey Respondents
Organized	296	22.4	31.5	24.5
Formal	257	19.5	15.2	44.2
Natural	561	42.5	46.5	31.3
Other	205	15.5	7.0	N/A
TOTAL	1319	99.9	100.0	

A Survey of Services of Eight "Willie M" Programs

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This paper describes services received by "Willie M., et al vs. James Hunt, et al" class action members in eight local counties in North Carolina. Services are described and utilization is examined with regard to age, race, and sex in urban areas and rural areas.

Reports of service utilization were gathered in interviews of Willie M. program staff in Orange, Person, Chatham, Durham, Vance, Warren, Franklin and Granville counties during March and April of 1983. These eight counties are designated by the State Department of Mental Health, Mental Retardation and Substance Abuse as Zone 8. The original hypothesis was that rural black youth would be receiving less services than urban white youth. After examination of the available data, this hypothesis appears correct.

POPULATION

In October of 1979, a law suit was filed by four minors--and "all similarly situated"--against James B. Hunt, Governor of North Carolina and other state officials. The suit was filed because it was thought that there was a group of North Carolina individuals under the age of 18 who "suffer from serious emotional, mental or neurological handicaps, which handicaps have been accompanied by behavior which is characterized as violent or assaultive and are, or will be in the future involuntarily institutionalized or otherwise placed in residential programs and for whom the defendants have not provided appropriate treatment and educational programs."[1]

A consent decree was entered by the defendants and the state agreed to provide appropriate education and treatment to these youth. Through a process of nomination and certification, additional minors have been added to the original four plaintiffs in the lawsuit. North Carolina currently has 1164 class members. As of 3/31/83, the certified "Willie M" population in Orange, Person, Chatham, Durham, Vance, Warren, Granville and Franklin counties can be described as indicated in Figure 1.

For the purposes of this paper, the class members living in Durham and Orange counties will be seen as living in "urban" areas and those living in Person, Chatham, Vance, Warren, Granville and Franklin counties will be regarded as living in "rural" areas. This designation was made due to population density and number of services available.

Figure 1: Willie M. Class Action
Members as of March 31, 1983

County	Black Males	Black Females	White Males	White Females	Total
Orange	6	0	14	1	21
Person	3	0	2	1	6
Chatham	5	4	7	2	18
Durham	22	4	19	3	48*
Vance	11	2	13	1	27
Warren	2	0	1	0	3
Granville	7	2	2	0	11
Franklin	2	1	1	0	4

*All members not represented due to unavailability of data about race or sex

SERVICES

As a result of the Willie M lawsuit and the consent decree, stipulations were set forth to provide needed education and treatment. All class members in North Carolina were to be provided:

1. Habilitation, including medical treatment, education, training and care, suited to his needs, which affords him a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capabilities permit with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency. Such habilitation shall create a reasonable expectation of progress toward the goal of independent community living. Defendants do not guarantee each plaintiff a "cure," but do guarantee each plaintiff a program of habilitation with a good faith effort to accomplish the goals set forth herein.

2. The least restrictive, i.e., most normal, living conditions appropriate for that person. Among the factors to be considered in determining the least restrictive living conditions appropriate for the individual are the need to minimize institutionalization and the need to minimize the possibility of harm to the individual and society.

and that,

3. The goal of habilitation shall be to enable each plaintiff, as appropriate for that individual, to move from: (a) Living and programming segregated from the community to living and programming integrated with the community; (b) More structured living to less structured living; (c) Group residence to individual residences; and (d) Dependent living to independent living.

4. Each plaintiff shall be provided such placements and services as are actually needed as determined by an individualized habilitation plan rather than such placements and services as are currently available. If placements and services actually needed are not available, the person shall be entitled to have them developed and implemented within a reasonable period. Prior to development and implementation of needed placements and services, the person shall be entitled to placement and services which meet as nearly as possible his actual needs.

To accomplish these goals, it was recognized that a wide array of services and treatment modalities would be necessary. Consistent, coordinated and creative efforts would have to occur to ensure that each Willie M plaintiff received appropriate help when that help was needed. A continuum of care was proposed along with case management to assess, plan, link, monitor and advocate for clients.

In the eight local counties a variety of services are available. They can be listed as follows:

Case Management Services: This service component provides planning and direction for the provision of services to a child and his/her family or custodian. Activities include assessment of client needs, planning for services to address those needs, linking and coordinating the flow of services to the client, monitoring the services provided to the client, and advocating for the client.

Public Schools: This component includes special services such as severely emotionally handicapped, emotionally handicapped, trainable mentally retarded, educable mentally retarded, and individually designed academic classrooms.

Vocational Services: This service includes employment obtained through Comprehensive Employment and Training Act and the Department of Vocational Rehabilitation.

Training Schools and Jail: Training Schools are a structured secure setting for children charged with breaking the law and incarcerated through the Juvenile Court System. Although not a treatment facility, individual and group counseling, and academic and vocational training may be available to students.

Summer Programs for School Children: This component serves school-age children with mental health/mental retardation problems who need summer programs to meet their individual needs and the needs of their families. These children may include those whose difficulties cause them to be "high risk" for court involvement during unstructured summer months and whose needs are not met in other generic summer programs (youth camps, etc.). Activities in these programs occur in a variety of settings, including developmental day centers, community recreational resources and day camps. These services are supervised by individuals who are knowledgeable about emotionally disturbed children and/or mentally retarded children. The services include child care, group socialization experiences, and recreation.

Residential Group Living: Moderate Supervision: This model offers residential treatment to children with moderate to severe problems including multiply-handicapped children. These are children for whom removal from the home is essential to facilitate treatment. Most children in this setting will attend public school, but some may attend day treatment or a job placement. These group homes provide adult role models, as well as group, individual and family counseling, liaison services to mobilize community and family resources, and social, emotional and cognitive training. Staffing is sufficient to supply a moderate level of supervision. Length of stay will typically be 6-8 months but may be longer.

Residential Group Living: Extensive Supervision: This model offers highly structured treatment to children with moderate to severe problems including multiply-handicapped children. These are children from whom removal from home is essential to facilitate treatment. Children in this setting may use day treatment or have a job placement. Some may be able to attend public school. For others, special education services may be available within the residential or day treatment setting. These group homes provide healthy adult role models, counseling, liaison services, and social, emotional and cognitive training. Staffing is sufficient to supply an extensive level of supervision including control of most aggressive behaviors. Facility may be locked if needed. Length of stay will be up to 2 1/2 years.

Residential Group Living: Extensive Supervision-High Management: This model offers highly structured and secure residential treatment to children with severe emotional or behavioral disturbance including multiply-handicapped children. These are generally aggressive children for whom a secure or locked environment is essential to facilitate treatment. These children may be unable to attend public school or vocational training, but they may attend a day treatment program. These homes provide adult role models; group, individual, and family counseling; liaison services; social, emotional and cognitive training. Services such as emergency services, educational or vocational training, day treatment and counseling may be provided. In general, a "home-like" atmosphere is maintained. Re-education or other models are used in this service.

Residential Group Living: Intensive Treatment (Non-Medical)-High Management: This model offers highly structured and secure residential treatment to children with severe emotional or behavioral disturbance including multiply-handicapped children. These children are highly aggressive and require a secure or locked enviornment. These children are unable to attend public school or vocational training. Full services are generally provided within the setting. Emphasis is placed on containing and controlling the child's violent, aggressive behavior and establishing positive behavior to replace negative destructive behavior. As soon as the child's behavior is under programmatic control, he/she is moved to a less restrictive setting. Length of stay is short-term. Activities emphasize social skills, emotional and cognitive development, daily living skills, vocational skills and recreational skills. Liaison services are provided to community and family.

Specialized Group Living: This model of service provides residential services for children who have extensive developmental, medical, and behavioral problems. Individualized programming is provided in the facility through an interdisciplinary staff, which provides constant supervision and programmatic structure. Children served by these programs are multiply-handicapped and can not be appropriately served in the public school.

Inpatient Hospitalization-Short-Term/Crisis: This service is appropriate for children with severe emotional or behavioral disturbances who cannot be served appropriately in a less restrictive setting. Services include a) psychological and medical diagnostic procedures; b) medication, psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation therapy and milieu treatment; c) medical care and treatment; d) supportive services; e) room and board. This service is based on the likelihood of stabilization within a short period of time and transfer to a less restrictive setting for continued treatment.

Inpatient Hospitalization-Long Term: This service is appropriate for children with severe emotional or behavioral disturbances who cannot be served appropriately in a less restrictive setting. Services include a) psychological and medical diagnostic procedures; b) medication psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation therapy and milieu treatment; c) medical care and treatment; d) supportive services; e) room and board. This service is for children with intractable problems who require intensive inpatient treatment to achieve stabilization and/or problem remediation. Length of treatment will typically be more than one year.

Mental Retardation Services:

Family Support Services - Outpatient or In Home: This component of service includes: family counseling, individual counseling for family members, parent training and information, parent support group, and subsidy for maintenance of the child in his own home. Combinations of these services may be made available to the parents, siblings and extended family members of children. The purpose of these services is to improve or stabilize the family living environment of the child, to minimize the

necessity for out-of-home placement of the child, to assist parents and family members to better understand the effects of the child's disabilities; and to assist parents in better effecting their child's developmental growth.

Transportation Services: This component provides transportation services to those clients who need such services in order to participate in programs or services. It includes transportation coordination, training of clients to use public transportation, assistance with car-pooling and planning, and the provision of segregated transportation, when appropriate.

Alternative Family Living: Specialized Foster Care: Children served in this component are placed in community foster care homes with specially trained and supported foster parents. Foster parents receive a monthly subsidy in order to meet the special needs of these children. Professional mental retardation/mental health workers provide training, case management and treatment services.

Respite Services: This component provides services for the families of mentally retarded or emotionally disturbed children who need periodic relief from the constant care of the child. Services may be provided either on a planned or emergency basis. While in respite care, the child receives supervised care, meeting basic health, nutritional, and daily living needs. Respite may be provided in a variety of models including center-based services with continuous care for up to 30 days; contracted services with citizens who use their home for respite services; and companion sitters who provide respite services in the home of the child.

Assessment/Prescriptive Services: This component provides periodic services to individuals in need of diagnostic evaluation, behavior assessment, and behavioral programming.

Advocacy Services: This component provides advocacy services (friendship, emotional support, assurance of quality services, freedom from abuse) to all individuals in need of such services. It includes the coordination, recruitment, and training of advocates as well as the assessment of client needs for advocacy and the appropriate pairing of a volunteer advocate with an individual client.

Wilderness Camp (Long Term): This component serves children ages 6-18 who have moderate to severe problems, whereby removal from the home is essential to facilitate treatment. Services are provided in an emotionally healthy, structured, therapeutic environment in groups of 10 or less. Adult role models provide supervision of school activities, peer interactions, and everyday living activities. Other services include recreation, group counseling to clients and parents, and client advocacy. Through outdoor living on a long-term basis (9-15 months) the child is helped to develop coping skills, self-esteem, and academic or vocational skills. Liaison services are provided.

Probation: This is a legally defined service of supervision, prescribed by the court in relation to charges brought against a juvenile.

Before and After School Program: This component provides services for school aged children who need care and intervention services before and after school hours to meet their individual needs or their families' needs. Services incorporate individualized programming in the developmental skill areas and are provided in a licensed day care setting.

Day Treatment (Partial Hospitalization): Moderate Services: This component serves children with moderate to severe problems. Children who have difficulty participating in partial or full-day public school programs because of the severity of their problems, as well as, children who require intensive intervention to prevent hospitalization are appropriately served in this setting. Day treatment services may be provided in conjunction with residential treatment services, such as day treatment planning, recreation, social skills dvelopment, group counseling, services to parents and client advocacy. Other services may include individual therapy and educational or vocational training and case management. Services are generally provided four hours per day, two to five days per week.

Day Treatment (Partial Hospitalization): Intensive Services: This component serves children with severe problems who are violent and assaultive. They require an intensive staffing level (staff: client ratio of at least 1:2) to enable the control and remediation of these children's problems. Services are often provided in conjunction with residential treatment including full educational/vocational services, diagnosis and treatment planning, recreation, social skills development, group counseling, services to parents, client advocacy, case management and individual therapy. The services are generally provided four to eight hours per day, five days per week.

Emergency Clinical Services: These services are provided for children in acute crisis who require immediate mental health evaluation and treatment. The service setting is non-residential and contact may be initiated in person or by telephone at any time. Based on the initial evaluation, preliminary diagnosis is established and treatment with referral, follow-up, and case management is provided.

Outpatient Treatment Services for Child: This component serves children with mild to moderate problems who can function in their natural environment. This service may also be used for children with moderate to severe problems in conjunction with other services such as partial hospitalization, alternative family living, and residential group living. Outpatient treatment services include screening, evaluation, diagnosis, treatment, follow-up, family intervention, case management and consultation to schools, courts, and other service providers.

Other Miscellaneous Services: Creative programming for individual children, such as Big Brother or special living situation.

Department of Correction:

UTILIZATION OF SERVICES

The following chart indicates which class members are receiving which services and service utilization by sex, race, and locale.

Figure 2: Service Utilization By
Race and Sex Based on Urban vs. Rural Residence

Service Number	Number of Children	Urban Black Male	Urban Black Female	Urban White Male	Urban White Female	Rural Black Male	Rural Black Female	Rural White Male	Rural White Female
1	138	28	4	33	4	30	9	26	4
2	36	12	1	13	1	3	0	4	2
3	11	6	0	2	0	2	0	1	0
4	11	2	1	2	0	3	0	3	0
5	0	0	0	0	0	0	0	0	0
6	6	1	0	3	0	0	0	1	1
7	0	0	0	0	0	0	0	0	0
8	2	0	0	2	0	0	0	0	0
9	0	0	0	0	0	0	0	0	0
10	4	1	0	2	0	0	0	0	1
11	0	0	0	0	0	0	0	0	0
12	9	1	1	4	1	0	1	1	0
13	7	1	0	1	0	2	0	2	1
14	4	0	1	3	0	0	0	0	0
15	1	0	0	0	0	0	1	0	0
16	9	1	0	0	0	2	0	5	1
17	14	4	0	3	1	1	1	2	2
18	1	0	0	1	0	0	0	0	0
19	0	0	0	0	0	0	0	0	0
20	5	2	0	2	0	1	0	0	0
21	3	1	0	2	0	0	0	0	0
22	2	1	0	0	0	0	0	0	1
23	28	3	0	3	1	10	3	7	1
24	1	0	0	1	0	0	0	0	0
25	1	0	0	1	0	0	0	0	0
26	14	2	0	4	1	1	1	5	0
27	4	1	0	2	0	1	0	0	0
28	3	2	0	0	0	1	0	0	0

Figure 3: Percent Utilization By
Race Based on Urban vs. Rural Residence

Service Number	Number of Children	Urban Black	Urban White	Rural Black	Rural White
1	138	23%	27%	28%	22%
2	36	36	39	8	17
3	11	55	18	18	9
4	11	27	18	27	27
5	0	0	0	0	0
6	6	17	50	0	33
7	0	0	0	0	0
8	2	0	100	0	0
9	0	0	0	0	0
10	4	25	50	0	25
11	0	0	0	0	0
12	9	22	56	11	11
13	7	14	14	29	43
14	4	25	75	0	0
15	1	0	0	100	0
16	9	11	0	22	67
17	14	29	29	14	29
18	1	0	100	0	0
19	0	0	0	0	0
20	5	40	40	20	0
21	3	33	67	0	0
22	2	50	0	0	50
23	28	11	14	46	29
24	1	0	100	0	0
25	1	0	100	0	0
26	14	14	36	14	36
27	4	25	50	25	0
28	3	67	0	33	0

CONCLUSIONS

1. The urban/rural population is evenly split but services seem to be more frequently used and/or more available in urban counties.

2. The Black population slightly outnumbers the White population but greater service utilization is reported for Whites than Blacks.

3. Five program services were not being used in Zone 8 at the time of reporting. These programs were Summer Programs for School Children (No. 5), Residential Group Living: Extensive Supervision (No. 7), Residential Group Living: Intensive Treatment (Non-medical)-High Management (No. 9), Inpatient Hospitalization-Short-Term/Crisis (No. 11) and Advocacy Services (No. 19). This apparent lack of use may be because of vague program descriptions. For instance, all case management involves advocacy, but this was not specifically named as a service provided. Another problem is the use of services on 3/31/83. Obviously, children would not be participating in a summer school program at that time of the year.

4. Racial imbalances seem to exist in the services: Public School (No. 2), Inpatient Hospitalization-Long Term (No. 12) and Outpatient Treatment Services for Child (No. 26).

5. Geographic imbalances seem to exist in the services: Public School (No. 2), Vocational Services (No. 3) and Inpatient Hospitalization-Long Term (No. 12).

Due to the informal survey methods and limited statistical significance, additional study is suggested to examine the issues of racial or geographical inequities of service utilization.

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Outreach Approach to Rural Mental Health Practice

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Mental Health services in rural communities can be most effectively and efficiently provided through the outreach approach. Through the use of outreach, services can affect many different aspects of the client's life. Resources, such as transportation, income, and health care are often limited and become barriers for clients in reaching out for help. A case management approach allows the clinician to expand the client's resources and facilitate the provision of a variety of needed services.

The Community Mental Health Systems Act (1963)[1] mandated that all mental health centers must provide five essential services: inpatient, outpatient, partial hospitalization, emergency services, and consultation and education. A comprehensive mental health center must provide programs in these five service areas to meet the needs of the area residents. Continuity of care, utilizing outreach and case management, is an essential component in Johnston County's Mental Health Centers' delivery system. The basic view is that to assist a client successfully, changes must occur in his/her total environment.

The extent of outreach services utilized may be affected by the ethnocultural and socioeconomic backgrounds of the client family. Involvement of the extended family in therapy or as a support system often varies. For example, in Black families, which are frequently matriarchal, the extended family may be large and readily involved in receiving services and providing support for the client. In white families, contact with the mental health centers is often initiated by the mother who then provides the follow-through and support during therapy. When family therapy is indicated in either case, extensive outreach may be needed. Utilization of family therapy seems more related to income and educational level than to ethnic origin. The comprehensive services offered by Johnston County Mental Health Center will be reviewed as various components of the outreach approach are discussed along with case examples to support the effectiveness of the outreach focus in rural mental health.

There are numerous components to the functioning of the outreach approach to rural mental health services. This paper discusses five of these components which are consistent with the Community Mental Health Systems Act (1963): case management, client visits in own environment, interagency cooperation, follow-up services, and consultation and education.

Case management is a critical aspect of services at the Johnson County Mental Health Center. There is debate in the literature concerning the definition of case management and the responsibilities and tasks it encompasses. Suber [2] describes the case manager as having five functions: assessment,

planning, linkage, monitoring, and advocacy. The goal of case management is coordinated care for the client. Intagliata[3] views the case manager as a vital component in the deinstitutionalization movement. He stresses the need for continuity of care and reduction of fragmented services. Johnson and Rubin[4] suggest that outreach and case management are social work functions. At Johnston County Mental Health Center both social workers and psychologists provide these services.

In a functional outreach oriented mental health system, case management would involve: (1) evaluating and assessing the client's presenting problem, (2) determining the services appropriate to meet the client's needs, (3) facilitating the delivery of those services. The case manager serves as the client's primary therapist, utilizing the most effective treatment modality for inpatient, outpatient, or emergency care. Clients may require assistance in procuring services from other agencies, such as housing, food stamps, and health services. This requires liaison work and interagency communications throughout the county. The case manager provides follow-up to the client as an essential element of outreach/case management services.

In the System Definition Study Report for Child Services at Johnston County Mental Health Center,[5] (1976) "case manager" was defined as, "The representative to serve and monitor the services needed by an individual client and to take action when that child drops out, is delayed in receiving services, or receives inadequate services. The case manager is ultimately accountable...for that client." The Child Services Program, serving ages zero to 18, provides individual, family and group therapy on inpatient and outpatient bases. Most of the referrals to Child Services originate with schools or other agencies. Child Services staff work closely with the school system by providing teacher consultation, school therapy groups, case consultation, and teacher training. Staff members also work with the Department of Social Services to serve mutual clients, as well as to provide training for specialized foster parents. The Child Services team refers children and families to other appropriate agencies such as North Carolina Memorial Hospital and residential treatment facilities. In these instances, case management may include arranging appointments, transportation, case conferences and advocacy.

The flexibility to visit with the client at home, work, or school environment is an integral part of the outreach approach. This approach enables the therapist to formulate a more realistic treatment plan for the client by developing a greater understanding of existing needs. Several problems occur in a service delivery system where middle-class clinicians serve people who are rural, poor and of different ethnocultural backgrounds. The clinicians usually lack first-hand knowledge of living without basic standards of food, clothing and heat. These needs must be met before a person can focus on higher level problems, such as social interactions or coping with other life stresses. Clients frequently distrust therapists who only function in the "sterile" environment of the service agency. Therapy must "begin where the client is," not where the therapist feels the client should be. For example, a strength among Black families is that they are happier with less than white families.

This perception affects the amount of life stress experienced.[6] A lack of awareness of this concept may contribute to a therapist increasing rather than reducing stresses for the client, as indicated in the following case example.

> J.J. was a 12-month-old, Black female who was being seen at a major medical center for treatment of a seizure disorder and developmental delays. The social worker at the medical center became enraged when he learned that the family lived in a home without indoor plumbing. He contacted the Department of Social Services in Johnston County to file a neglect complaint, stating that this family was obviously neglecting the child's basic needs. The case manager/therapist who had been working with the family knew that the child was kept clean and well fed, given adequate medical attention, and protected from dangerous situations. J.J.'s father became upset about the allegations. He began to feel that he was a failure as a father and as a provider for his family. The focus had been diverted from the real problems that the child was experiencing and was refocused on irrelevant issues which drastically increased the stress factor in this family. It took several weeks to redirect the family's attention successfully to the appropriate treatment issues and resume the therapeutic regimen.

Visits to the schools, workplace, day-care center, sheltered workshop or group home, allows the therapist to become acquainted with members of client's social support system and family system. Extended family members and significant friends may be involved with the client but are unwilling or unable to go to the Mental Health Center. A noted strength in the Black culture is a tendency to have greater involvement with extended family members and to use these family members to help in solving problems.[7] Often as members of the support system become acquainted with the therapist, they become more willing to encourage the patient to seek help from the mental health center. This is an educational benefit of the outreach approach. Royse and Turner[8] describe strengths of Black families to include an acceptance of illegitimate children and elderly into their homes. The extended family is often very strong and accepts others readily into their homes, as indicated by the greater percentage of Black foster parents than white foster parents.

There is a strong work orientation and self-help characteristic found in rural counties, where farmwork is the primary source of income for many families. The seasonal work of farmworkers causes difficulty in mental health service delivery, from early spring through late fall. The providers need to go to the clients. More Blacks than whites are engaged in farm labor, and frequently both parents in Black families must work to support the family.

Transportation is a critical need in rural areas without mass transit systems. Families in poverty often cannot afford a reliable car and must pay friends or relatives to drive them to clinic appointments. The Department

of Social Services operates a van system to medical centers for Title XX-eligible clients. However, clients who are marginally eligible may not receive this service. The case manager/therapist at the mental health center may facilitate a referral to the Department of Social Services for Title XX services or provide transportation for clients who are ineligible for the van service to major appointments. Transportation needs may not be identified unless the client is viewed in his total environment. In particular, children who are clients of the mental health center are often unable to attend appointments regularly at the center because their parents work or because transportation is unavailable to them. The outreach approach enables the therapist to visit with these clients in the school setting or at home.

The outreach approach utilized effectively in a comprehensive, rural mental health center enhances the delivery system in all services, including child, adult, mental retardation, substance abuse, and consultation/education programs. Below is an illustration of the effectiveness of visits at client's environment.

> R. is a 59-year-old white, married male who is unemployed. He has been diagnosed as having "Schizophrenia, Paranoid Type," and has been a client of the Mental Health Center since 1978. R. was hospitalized at intake an acute episode of schizophrenia. He dropped out of treatment several times, and was consequently admitted involuntarily for inpatient treatment. Over the course of years, the therapist made home visits to encourage the client and the family to continue in treatment. Ultimately, by involving his sons in providing treatment, R. has attended regularly since 1981. The therapist states that home visits promoted trust between himself and the client and family. R. feels extremely uncomfortable at the Mental Health Center. Family involvement provided the needed support to help him keep appointments and follow through with treatment plans.

The Adult Services staff at the Mental Health Center, serves clients from age 18 and above and utilizes individual, family, and group treatment for inpatient and outpatient care. Home visits and workplace visits are integral parts of the treatment regimen. The staff provides counseling at Unity House, Johnston County's partial hospitalization program. Referrals to Vocational Rehabilitation, Social Services, nursing homes, and health care agencies are often initiated by the Adult Services staff who then coordinate the delivery system and the follow-up services for clients.

Interagency cooperation is essential to the success of outreach services in community mental health. Referrals from one agency to another can be followed closely, and duplication of services can be reduced, when adequate cooperation and communication exists. With the consent of the client or guardian in the case of a minor, information can be shared

between agencies working with a client. This information may be helpful in treatment planning in ensuring that the best available care is provided to the client in a non-fragmented manner. Johnston County Mental Health Center is involved with numerous community agencies in providing services to clients. Some of these agencies include: Health Department, Social Services, Vocational Rehabilitation, Employment Security Commission, the court system, the school system, Johnston Technical College, and law enforcement agencies.

In Johnston County, mental retardation services begin with the Early Childhood Intervention (ECI) program for young children at risk for developmental disabilities through a home-based, parent training program. Information and training about child development and child care is provided to the family in order to help their children reach their fullest developmental potential. It enables the child's caregivers to identify and utilize resources available in their home. It is not uncommon for families to be isolated due to lack of transportation and/or telephone. ECI staff works with the Departments of Health and Social Services as well as physicians and other referrring agents.

The ECI staff members are available to talk with civic groups and other agencies about their services and about child development. One of the major outreach programs that the ECI team participates in is a prenatal class co-sponsored with the Health Department. This program provides prospective parents with information about pregnancy and early child development as well as information about mental health services.

When a child reaches four years of age, he/she is referred to the developmental day school, Head Start, or other appropriate services. Mental Retardation staff provide consultation services, therapy, transportation, group home care, and respite care. The Mental Health Center operates a transportation system that serves Johnston County Industries, the developmental day school, and the Unity House (partial hospitalization) Program. The provision of transportation facilitates county residents receiving the services they need.

The Johnston County Interagency Council for the Developmentally Disabled, which is coordinated by the Mental Retardation Services at the Mental Health Center, is an example of interagency coordination and cooperation. Members of the Council include representatives from Mental Health, O'Berry Center, the Health Department, the Department of Social Services, New Horizon Developmental Day School, the school system, the Developmental Evaluation Center, and other agencies who serve developmentally disabled clients. This Council meets on a monthly basis to discuss referrals to various agencies, to plan delivery of services, and to discuss policy decisions regarding service delivery for developmentally disabled clients. Information is shared about referrals, in order to keep various agencies abreast of the progress and concerns of clients.

Other coordinated efforts are the Community-Based Alternatives Committee and the Youth Task force which focus on juvenile delinquency prevention. Representatives from the Child Services Program at the Mental Health Center

are active on both committees along with professionals from the Department of Social Services, Juvenile Court, the school system, general public, and the Health Department. Members of both youth-oriented committees are aware of the potential for delinquent behavior among youth in poor, rural communities. By initiating and funding primary prevention projects, such as therapy groups in the schools, the Secrets program (an alcohol and drug prevention program in the fifth grades at schools), Summer Recreation Program, and One-to-One volunteer program, these interagency committees have attempted to redirect the energies of youth in the county.

Follow-up services are another important component of the outreach approach to comprehensive mental health services. By maintaining contact with clients who have been discharged from the mental health system, the clinician can facilitate the provision of additional services that may become necessary to maintain the client's ability to cope in the environment by utilizing skills developed in therapy. Support groups are one method of providing follow-up services in rural communities.

The Substance Abuse Program at the Mental Health Center provides individual, family, and group counseling sessions on an inpatient, outpatient, and emergency basis. In conjunction with counseling services, a client and his family members may be encouraged to attend meetings of Alcoholics Anonymous, Alanon, or Alateen. The Substance Abuse Program provides classes for adults on probation, alcohol and drug education classes for parents, drug education programs in the schools,presentations to civic groups, and an ongoing recreation program for recovering alcoholics. Clients may be identified through their participation in the drug and alcohol education training school operated by the Mental Health Center. Alcoholism counselors facilitate referrals to rehabilitation centers and to the halfway house as well as provide crisis intervention and court services. Once an alcohol client is stabilized and does not require direct therapy, the Substance Abuse Program provides follow-up services by continued participation in the Alcoholics Anonymous, the Alcohol Recreation Program, support groups, and ongoing classes. Support groups and classes offer peer support to clients who may be in jeopardy of reverting back to old habits.

Follow-up services are provided by Early Child Intervention staff who are required to make one-month and six-month follow-up visits to discharged clients. These visits are to determine developmental progress and the necessity of referrals for additional services as the child grows older. Other services in the Mental Health Center maintain ongoing contact with former clients for a period of a year by phone calls or visits.

Consultation and Education Services attempts to reach out to the community and reduce the stigma attached to mental illness. The Consultation and Education coordinator in Johnston County writes a weekly column in the local newspaper addressing a variety of subjects and services of interests to residents. Volunteer Services, a component of Consultation and Education Services, administers the One-to-One program, the Secrets program (an alcohol-prevention program for fifth graders) the NEIGHBORS program, Operation Santa Claus, and various support groups. Other

Consultation and Education activities include an annual Halloween carnival held at the Mental Health Center. The primary goal of this activity is to invite the public to view the Mental Health Center in a positive way and to become acquainted with staff members who are interested in the community. The carnival provides a positive environment for children to celebrate Halloween without getting into trouble or spending much money. The Mental Health Center, through Volunteer Services, sponsors a Girl Scout troop. All Mental Health Center staff members have an opportunity to teach adult education classes in conjunction with Johnston Technical College. Some of the classes offered include: Parenting, stepparenting, assertiveness training, stress management, and time management. The Consultation and Education coordinator is available to provide information to students, interested citizens,and civic groups on a variety of subjects. The Consultation and Education coordinator attends the Human Services Council, an information-sharing group involving 20 agencies in the county which meets monthly to discuss services and policy issues.

CONCLUSION

Considering the current reduction of budgets of many mental health centers, outreach may seem like an extravagant approach to mental health servicies. However, it may be an effective and efficient method of providing less costly services. As deinstitutionalization of psychiatric hospitals continues,the need for comprehensive community services increases. For example, there has not been any admissions from Johnston County to Dorothea Dix Psychiatric Hospital since 1980. The mental health center has developed programs to provide comprehensive services to psychiatric clients which prevents institutionalization.

Case management, visits outside the center, interagency cooperation, follow-up services, and consultation and education are all integral components of the outreach approach to rural mental health services. The importance of these components in providing services and in promoting positive mental health has been recognized in Johnston County.

DEMOGRAPHIC CHARACTERISTICS

RACE - SEX

	White	Black	Total
Male	45%	14%	59%
Female	32%	9%	41%
Total	77%	23%	

AGE

14 & Under	15%
15-20	9%
21-34	26%
35-44	20%
45-54	13%
55-64	9%
65 & Over	7%

REFERRAL SOURCE

Self	36%
Family	20%
Courts, Police	11%
Private Physician	7%
Public Health/Hosp.	7%
Schools	6%
Social Services	3%
Employer	3%
Other	7%

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Reaching Out to Rural African Americans
An Underserved Population

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Providing social welfare services for African Americans in rural settings remains an area deserving further redress. Although formal helping services to rural populations have increased primarily as a result of the services provided through Title XX and the efforts of the National Institute of Mental Health, the rural African American population remains underserved and has benefitted least from these services (Leiby, 1978: 305-310; Prigmore and Atherton, 1979:95). Even organizations, such as the National Urban League and the NAACP, established specifically to provide services to African Americans, have done little to meet the needs of the rural African American. Southern rural African Americans continue to "... represent the most intractable core of poverty in the nation" (Nordheimer, 1975:1). They are still underserved and entrenched in poverty. Moreover, they represent the group often deprived of needed health care, nutritious food, safe and adequate housing, and employment opportunities (Ginsberg, 1977:1230). Our discussion will focus on African Americans in the rural South and the institutional and sociocultural influences affecting their low utilization of available services. We will conclude by presenting and briefly discussing strategies or service delivery patterns for reaching and serving the rural African American.

To further identify this underserved population, we begin by defining the term "rural." Definitions of rural vary and range from the classification based on the definition of Standard Metropolitan Statistical Areas (SMSAs) with an absolute population density to DuBord's rural-urban continuum that considers the fluidity of the rural population. DuBord views communities as open systems with diffuse and overlapping systems (Farley, 1982:6-7). Some writers contend that any search for a universally accepted definition of rural people is wasteful because people in rural areas are more similar to people in non-rural areas than they are different. We believe that any definition of a rural setting, however, will produce an environment that is quite different from the environment in an urban area. The ecological notion of rural deals with the distribution of people and space including the environmental systems of the community. The major idea of occupation continues to be farming or nature-related production despite major changes in rural family farming. The sociocultural concept of rural life is associated with several themes: social isolation, informal and natural support systems, a sense of independence and self-reliance, conservative folkways and kinship networks.

VARIABLES INFLUENCING UNDERUTILIZATION

The social and cultural themes of the rural setting, compounded with the oppressive experiences of the African American, create a unique environment for social service delivery. We have selected institutional/organiza-

tional and sociocultural influences as two broad categories needing further exploration if rural social work is to become effective.

Institutional/Organizational Influences

As we discuss institutional/organizational policy, a number of variables come to mind. First, the smooth operation of any organization, such as local department of social services demands the existence of a form, a consistency, and a stability to work with clients. Yet, the same factors that contribute to the organization's efficiency create barriers to effective service delivery. Many organizations have a number of policies which create these barriers. An agency that is open from eight to five excludes a tremendous population of individuals who work as farm laborers and factory workers and, therefore, cannot take off the necessary time to travel to the agency. The fact that many agencies in rural areas are located in the county seat may mean that residents are likely to live a great distance from the offices. As is often the case, many residents live closer to a neighboring county office than they do to the one in their county. Agency policies, nonetheless, would generally demand they they seek services in their own catchment areas. The agency's reluctance to deal with such problems effectively may mean that many eligible and needy African Americans remain underserved.

Another factor contributing to underutilization may be staff composition and staff perceptions. The staff in many social welfare agencies may find themselves totally unprepared for the task of rural social worker (Fenby, 1978: 162-163). Since acceptance of social work professionals in rural communities comes slowly, workers may become frustrated with the endless and often thankless tasks required to provide services. The dearth of information on rural social work professionals have the culture-specific knowledge and expertise desired for practice in rural settings (Martinez-Brawley, 1980:43).

Social agencies/organizations in rural areas do not operate as isolated independent entities. They often reflect the values and beliefs of their local communities. Among these values and beliefs are the concepts of local control, the belief in absolute familial independence, racism, and a residual view of social welfare (Osgood, 1977:41; Cheitman, 1981:23). A recent newspaper article on a rural North Carolina county shows that these beliefs remain prevalent. This rural county is burdened with declining growth in revenues while its poor and near poor residents have increased dramatically in the recession. City and county officials maintain the position that they cannot pick up the deficits created by federal cutbacks. They contend that if the federal and state governments cannot afford funding of social programs,then the county cannot afford it. Even during the 1960's and 1970's when federal aid was more readily available,the county's officials regarded it suspiciously. They never applied for federal community development grants because they thought it was "un-American" (Eichel, 1983:1A). A further illustration of how community values and beliefs influence agency policy can be seen in the underutilization of existing and available service programs.(Neely, 1979:335) found in Hancock County, Georgia that Caucasians saw the Early and Periodic Screening Diagnosis and Treatment (EPSDT)programs as just "...another giveaway welfare scheme primarily benefiting blacks." Since such attitudes exist, it is easy to see how some social agencies might exclude several available service programs simply to avoid serving the African American client.

Sociocultural Influences

Rural African Americans pride themselves in taking care of their own and relying on their ingenuity, hard work and informal helping networks. To resort to outside governmental help is viewed by many as a loss of independence and self-sufficiency. It is also status-diminishing to the rural individuals and their families. The rural custom of bestowing status based on familial ties makes seemingly individual decisions and behavior reflections on entire kinship networks (Ford, 1965:39). Cheitman (1981:23) found in a study of rural women that often women in need of services did not request them because of pressure from the extended family.

In conversation with therapists at one rural North Carolina mental health center, cases were cited where family members would much rather see a child labelled delinquent than emotionally disturbed. Being delinquent was a reflection on the individual while being "mental" represented a reflection on the entire family for generations.

Religion represents another very significant sociocultural factor. The religious beliefs of some rural African Americans contribute to their lack of awareness or acceptance that a specific type of problem might be appropriate for outside intervention and assistance. Because of a strong adherence to the Protestant work ethic, they embrace a residual view of formal helping organizations. Problems more often are viewed as an individual's failure, both by the community and themselves, than a failure of the larger social institutions to meet their needs and provide adequate support (Osgood, 1977: 43).

Many rural individuals approach suffering as a natural part of life that they must endure in order to receive their reward in heaven. The belief in supernatural causation is not unusual nor is the belief in waiting for supernatural intervention. The inability of rural social workers to discuss religion openly and incorporate it into the treatment plan results in misuse of a strong and influential reality of African American culture.

Another environmental factor influencing the utilization of services among rural African Americans is the heavy reliance on the informal news network. News and information about social service programs transferred informally often becomes inaccurate and confusing. It is also passed on with personal interpretations and values which may negatively influence the receiver of the information (Cheitman, 1981:24).

The rural individual, in general, has a cultural mistrust of outsiders. Formal education, experience, and agency affiliation are not sufficient grounds for rural residents to confer status or trust (Jenkins and Cook, 1981:415). It is much more important to have community family ties, a personal endorsement by respected community citizens and/or culturally appropriate interpersonal and informal behavior. This mistrust of outsiders is compounded for the rural African American with a general mistrust of Caucasians, local governmental officials and employees. This reluctance

to trust outsiders is not altogether unfounded. Outsiders often have little knowledge or appreciation for local culture, customs and community history. In the not-too-distant past many of the social service agencies that were established to help the needy in fact openly practiced discrimination (Figueira-McDonough, 1979:214, 216).

African Americans have often been denied access to formal helping, such as in public and private service agencies. Therefore, they have been forced to rely on what they had available. Alternative healing systems, indigenous natural helpers, and informal support systems were embraced, developed and accepted as a part of the African American culture. A discussion of these systems follows.

HELP-GIVING SYSTEMS

Alternative Healing

Due to the high cost and inaccessibility of traditional medical care, many rural African Americans continue to utilize their folk healers in time of need. These informal alternative healers have various names ranging from folk healers, conjurers, rootworkers, voodoo doctors and spiritual or faith healers. Whatever these alternative healers are called, it is important to recognize that their practice is not a random haphazard collection of beliefs and practices. It is instead representative of a well-organized and usually consistent theory of medicine. This theory of medicine or knowledge is based on ideas about the nature of human beings and their relationship with nature, the human environment and the supernatural (Wilson, 1982:382; Reul, 1979:224-234). The reluctance of mental health workers to accept alternative healing beliefs as viable has resulted in mislabelling clients who expressed a belief in "voodoo" as mentally ill (Wilson, 1982:380). Fear of labelling and ridicule often forces African American clients to avoid sharing accurate information.

Indigenous Natural Helpers

Rural African Americans depend much more on informal and natural helping support systems, such as the church and kinship networks, than their urban counterparts. Some of the factors contributing to these patterns of utilization include fragmentation and sparcity of formal service systems, cultural and geographical distance between client and service and rural values stressing taking care of one's own and self-reliance. Discrimination and segregation have reinforced the need to rely on self and kin. These networks are not always readily identified by"outsiders." However, there is usually a core group of people who function in these capacities (Jenkins and Cook, 1981:415). These people are indigenous to the community, share the same values and hardships, offer concrete services, and direct advice or function as brokers with influential others.

STRATEGIES FOR OUTREACH AND INCREASING SERVICE ORGANIZATION

Due to the lack of public transportation, low rate of car ownership and the vast distances within a catchment area, rural human services need to be more flexible in their service delivery models.

Two possible alternatives are satellite centers and circuit-riding service providers (Jenkins and Cook, 1981:415). Instead of concentrating all of the services in one location, several satellite centers could be established throughout the catchment area. If satellite centers prove too costly, some effort to establish reciprocal service agreements with neighboring catchment areas should be made. For the circuit-riding service provider, sites throughout the catchment area could be established with the staff rotating through on a regular basis. Local churches, schools, community centers and volunteer fire stations would be excellent alternatives that are more convenient and less theatening. In these alternatives, special consideration must be given to ensure confidentiality which is so highly valued in small face-to-face communities.

Social work professionals need to establish working relationships with indigenous community helpers and begin to understand the intricacies of informal helping networks. Utilizing indigenous community residents as culture brokers may hasten trust building and entrée into the rural African American community. They may also serve as invaluable sources of referral. In many instances training natural community helpers to work in the agencies is a viable alternative.

The use of cross-cultural inservice training is important in teaching workers how to decrease cultural dissonance between worker and client and in developing policies designed to meet specifically the needs of the rural community. The use of indigenous community helpers in assisting with the training would be beneficial.

More effort to educate the community formally is necessary to combat negative attitudes regarding outside help and to aid in identifying problems appropriate for intervention. Pamphlets and brochures can be distributed to people experiencing crisis or stress. Undertakers, volunteer firemen, policemen, ministers, beauticians, barbers, and alternative healers may be utilized to provide people with accurate information about outside intervention. It is important to get coverage in the local newspaper; this often entails influencing and educating the editors and staff.

If receiving human service assistance is stat s-diminishing in the rural community, then being a social worker is vie d as a low status profession. This is a problem that social workers have often faced, but it seems to be true especially in rural areas. Students often report tremendously negative reactions from family and friends when they express an interest in social work as a profession. The belief is that all social workers' responsibilities are limited to handing out "welfare checks and food stamps" to lazy and irresponsible people. Since many of the cultural barriers can be decreased by hiring social workers indigenous to the community or rural setting, it is important that social agencies begin to educate the community about the roles of social workers. This education may begin at the junior high and high school levels with professional social workers taking an active part in local school career-day activities, providing lectures to vocational classes and encouraging field trips to appropriate public and private social agencies.

SUMMARY

Historically, Southern rural African Americans have comprised one of America's most oppressed and impoverished groups. Many of these families have never escaped the cycle of poverty that began during slavery. There exists among these people a vast resource of human potential which is being denied full opportunity to develop and flourish. We believe that rural social workers have a unique opportunity and a responsibility to offer this population culturally-sensitive professional services which will begin to make a difference in their lives. In order to do this, they must address the causes of underutilization of the existing services and develop new services designed specially for the rural setting. The rural social worker must be as innovative and as creative as possible in designing new patterns of service delivery. The strategies that we have presented here represent a beginning. Rather than providing a solution to the problems of the underserved African American in the rural South, our presentation should facilitate further discussion and exploration with regard to patterns of service delivery.

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APPENDIX

These vignettes may be useful in the classroom and/or agency inservice training. Sensitive and open discussions of the cultural implications of these vignettes is an easy and workable way for social workers to begin to identify and understand culture specific materials unique to the rural African American.

1. An elderly grandmother has been keeping her latency aged grandson for one year. He had previously lived in Newark, New Jersey with his parents. He was referred to the county mental health department clinic because of acting-out behavior in school. Their first appointment was traumatic and confusing.

2. A ward of the state moved into a foster home at age eight (8) and has remained there for seven (7) years. She has been informally adopted by the community-kin network. The Department of Social Service worker has found a couple willing to adopt the girl. The worker tells the foster mother and the girl of the perspective adoptive home in a zealous manner.

3. An adolescent in a physically isolated area was taken (by the social worker) to the county health department and diagnosed as having herpes. She refused to believe that the disease was contracted sexually because it goes away and recurs periodically. The adolescent associated the disappearance and reappearance of the lesions with the supernatural powers of her boyfriend's ex-girlfriend.

4. The social worker is counseling a client in the county mental health office. The client begins to pray as they talk about her teenage son's drug problem. The client begins to talk of the miracle of God and has a religious experience, i.e., walling of the eyes, jerking, and speaking in "tongues."

5. A counselor in a public health department is talking with an adolescent about her pregnancy. The adolescent is from a family with a very strong religious background. The counselor suggests several options that may be taken by the girl and includes adoption and abortion.

Scenes From a Family: Family Therapy with an Appalachian Family

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The region of Southern Appalachia hosts a variety of images reflecting the uniqueness of the socio-cultural milieu. The Appalachian family presents a complex, paradoxical, and sometimes enigmatic picture to the mental health service provider. This paper reflects how one agency has attempted to create a model for working with adolescents and their families that is sensitive to the characteristics and values of families in Western North Carolina. Mountain Youth Resources is a private nonprofit agency that offers home-based family therapy and a temporary shelter for youth in a four-county area. The emphasis of the agency is on early intervention to prevent family deterioration and on community resource development to aid the family. The social workers at Mountain Youth Resources (MYR) are trained family therapists.

Following a description of family therapy concepts, this paper will explore characteristics of Appalachian families. A representative family will be presented, in which the initial focus is on the adolescent as the identified client. The focus widens to include family dynamics and cultural values as well as therapist values and orientation. The paper will address the selection of therapeutic techniques that are responsive to the needs of families in rural Western North Carolina.

Families in Western North Carolina are similar to families elsewhere, in that they may have problems between the parents or among parents and children. Families usually attempt to work out problems on their own, but sometimes find it beneficial to seek help outside the family system. In some instances, families experiencing problems are brought to the attention of community resources by an outside source. If child abuse is suspected or if a child is guilty of illegal behavior, or if a child is withdrawn and performing poorly in school, a community resource person may intervene in the family system. Mountain Youth Resources views outreach-family therapy as a vital intervention strategy with families in need of some outside support.

Mountain Youth Resources was founded in 1979, as a direct result of House Bill 456, which encouraged the development of community-based alternatives to juvenile incarceration. The goal of this legislation was to keep youth in their community and to use local resources to help children and their parents strengthen their family unit. MYR offers services to youth, ages 10-17, in Cherokee, Swain, Jackson and Haywood counties. The youth are referred by the courts, schools, social services, and other agencies. They have been

identified as having trouble at home, in school or in the community. The services offered are home-based family therapy, development of community aid to the family and a temporary home shelter.

A philosophy of MYR is that the family is the best place for a child to grow and is the ideal means of support and guidance for children. Through experience, MYR finds that most parents of troubled children desire to become more effective in helping their children achieve responsible behavior. The social worker, therefore, helps the family work together on their difficulties and resolve problems. Hopefully, the result will strengthen the family unit, as well as encourage the growth of individual family members.

In the scope of family therapy, the family is viewed as a system. Each family is different and change within the family is constant. Each member affects and is affected by every other member. Thus, each action on the part of one member creates a sequence of further actions and reactions on the part of other members. As an example, acting out behavior by an adolescent, such as running away, can represent a need of the family system rather than an expression of the adolescent's need. The social worker maintains this perspective as s/he explores the needs within the family for the adolescent's acting out behavior.

Families have intricate mechanisms for adapting to change and maintaining stability over time. Families with fewer adaptive resources tend to be more rigidly organized with more procedures for maintaining homeostasis. Individual treatment may outwardly threaten the other family members who view an outsider, the therapist, as trying to pull the individual away from the family. In outreach family therapy, the therapist enters the family system and all family members actively become involved. Instead of focusing on individual pathology, parents are helped to improve their parenting skills and to gain confidence in managing the "problem child." This positive experience may be generalized to other children and other issues. Out of this more effective system, the adolescent or "problem child" becomes more competent, hopefully, and in the long run, the youth will become an effective and confident spouse and parent.

In general, the concepts of family therapy are applicable to families everywhere. However, special characteristics are considered when providing services in a rural mountain community. Respect for the rich heritage of the mountain folk is important. In some ways, the people have changed very little over the years. In other ways, their lifestyles are undergoing profound changes. A sensitive awareness of the particular characteristics of Appalachian families is necessary for a worker attempting to offer family therapy, or any mental health service in the region.

The mountaineer has a strong sense of individualism. Historically, he was his own provider, his own law and protector, his family's agent to the outside world, and even teacher to his children. The family functioned independently, both economically and socially. Through the generations, this independence became individualism. Individualism reflects self direction. A man may work for his own gain or well-being in mind. A strong value is placed on "helping our own" and maintaining self-sufficiency. While this has many positive

qualities for survival, the tendency to meet most needs within the family may weaken the incest taboo.[1]

The self-centered independence inhibits involvement in groups. If a mountain person finds that a group does not meet his personal needs and interests, he will not continue in the group. In today's modern world, it is increasingly hard to "go it alone." Yet, the mountain family may be reluctant to take advantage of community services or classes. Outreach services, such as Agricultural Extension Homemakers, take resources into the isolated areas. Outreach services require time, manpower, and transportation funds. Intervention in the closed system may be difficult, as often the service providers are outsiders, who are viewed with suspicion.

Outsiders have frequently brought in different social and value systems. The mountain folk are strongly bound to the past through preserving old traditions and ideas. For example, tomorrow is not approached with pleasant anticipation, but rather resignation of the difficult and hard times ahead. Although the men and women work very hard, they have little material wealth. Land is limited and maintaining productivity is difficult.[2] An example of the hard work-low yield of some mountain land is the economic dependence on small acreage of burley tobacco. The families work nine months to raise tobacco for market with a hope of $3,000 profit, and all can be lost by too much or too little rain. With such gloomy expectations, the mountain folks look backward to yesterday.

The mountain people tend to be controlling of their behavior. They tend to be "existence oriented,"[3] or geared toward achieving only the basic goods needed for survival and a minimum of comfort. Their frugal nature contributes to their uneasiness with expansiveness of any kind, including emotional expression and physical movement. This orientation results in very conservative ideas in every aspect of life, and acceptance of the status quo.

A fatalistic attitude is a controversial characteristic of the mountain people. Due to the harshness of the land, the people developed a sense that they were not at fault for poor results of their labor. Although discouraged by their way of life, they were committed to it as being fundamentally right. The religious quality of the fatalism is pervasive, even for those who do not attend church. Endurance and acceptance of the Lord's Will contribute to an absence of personal responsibility and initiative concerning the circumstances of one's life. There exists a passive resignation to accept undesirable conditions as a way of life, with little resistance, questioning, or complaining. This attitude is expressed as "no matter how much or how little you take care of yourself, you're going to die when your allotted time is up" or "We have to take what the Lord sends us; He knows best."[4]

Another characteristic of mountain people is that they tend to be action-seekers. Although they may have a secure job, this is not seen as important to self-image. The job is something to endure until the evening or weekend comes. Then, the men can go hunting or fishing or have a card game or party. The women can attend to the affairs of the home, such as canning, cleaning, and child-care. Routines are not desirable, as one must be ready for spontaneous activities. Therefore, committing time for meetings is difficult.[5] This is another reason for outreach services.

The close-knit quality of mountain families lends some security to mountain life. However, the members are bound to one another by ties of emotional dependence, which increases insecurity. There is ambivalence in the family relationships. On one hand, members are dependent upon one another for security. On the other, they are suspicious of each other's motives. The family system is further complicated by the tendency toward large extended family networks. One Western North Carolina man noted that 67 of his relatives lived in the same hollow! The family does not conform to an outsider's nuclear family expectations. Sons and daughters settle near their parents. They will accept other family members, such as parents, aunts, and grandparents, into their homes. Large families were viewed as a blessing. It was believed that more children provided more help around the farm. However, family size is decreasing in rural areas as employment of women is increasing. Children are still highly valued for giving meaning to their parents' lives.[6] Mothers will often say their children come before everything else. Ironically, discipline is frequently harsh, but child-rearing is generally permissive. Mothers often express powerlessness in controlling their children who are difficult to manage.

Because the mountain family tends to be a closed system, input from the outside may be difficult. There are existing social structures, such as church, that traditionally engage the families with others. However, existing institutions such as schools, medical facilities and the state police may be looked on with suspicion and hostility. Folks in the mountains respond more favorably to individuals, rather than agencies. They are not impressed by professional status. Agencies such as mental health, social services and family services are particularly suspect because the people believe that they should be able to take care of their own. An important way for a worker to join with the family system is to use local terminology and to talk about the person's experience, such as gardening and woodcutting. This may be seen as an expression of respect for central aspects of the mountain family's way of life.

Since many social workers coming into the mountain region are from a white, middle class value system, it is especially important for them to develop a sensitive awareness of the local cultural mores. With this in mind, the experience of working with Appalachian families can be challenging and rewarding. The following example of a family's case history with MYR illustrates some of the process of outreach family therapy. The family is actually a composite of many families seen by the MYR social workers.

The Buckley family was referred to MYR by Social Services following an abuse complaint. After an investigation, family therapy was recommended as the most beneficial treatment for the family. The abuse complaint was related to a spanking incident with the youngest child. In addition, Monroe, the 16-year-old son, was reported as being "disrespectful" towards his step-father and trying to discipline the other children.

John and Betty Buckley, the identified parents, were married two years ago. Betty had two previous marriages, with three children from the first marriage and one child from the second marriage. This is a first marriage for John, and they have no children from their union. Both of Betty's previous husbands were abusive to her; one died of a heart attack and the other is in prison for

manslaughter. She works as an LPN in a local hospital, where John is employed as an orderly. Betty is from a local family and has achieved an unusually high degree of professional attainment for her family. John's family moved to North Carolina from Florida six years ago after his father was disabled. In spite of Betty's professional success, she is passive in relationships and exhibits a sense of learned helplessness. She shows some characteristics that might suggest she had been physically or sexually abused. John is an only child. Under stress, he exhibits poor impulse control. In addition to adjusting to a marriage, he is finding it very difficult to be an effective parent.

Betty and John live in close proximity to Betty's mother, Beulah. Beulah is very involved in the family situation. Since her husband died in 1978, she's been more involved with all of her children. As a wife, Beulah was overtly submissive, but controlled her husband through manipulation. Beulah tolerated Betty's first husband because he was a hometown boy. She despised her second husband because he was an Indian and acted domineering and violent. She does not value John because he is a Floridian. Generally, she considers him too young and not good enough for Betty. She demonstrates her disapproval by aligning with Monroe, the first born, whom she considers the "man" of the family. Beulah contends she doesn't want her grandchildren raised by an "outsider."

As the oldest child, Monroe had a good, but distant relationship with his father. He saw him only occasionally. Monroe's relationship with "Husband #2" was strained. This man was violent with Betty, and Monroe felt protective of her. Since Monroe had assumed the role of parental child, it was predictable that he might have issues with John about discipline. When John spanked one of the girls excessively (the reason for the protective service referral), Monroe became very hostile. They have not resolved the conflict openly. Monroe, acting like a parent, interferes with John's disciplining the children.

Several problems seemed evident at the onset. John was an "outsider" trying to fit into an indigenous family. Grandmother Beulah was involved in interfering with John and Betty's marriage. Monroe was unwilling to accept John as head of household or disciplinarian. Each of the adults had a different perspective of an appropriate level for Beulah's involvement in the Buckley family. Betty was torn between siding with her mother and siding with her husband. Beulah wanted to run the whole show and triangled Monroe in, as a way of undermining John's power. Therefore, John became more resistant to accept any discipline efforts toward the younger children by Monroe.

The following goals were established by the therapist:

1. To relieve Monroe of the pressures of the parental-child role. He had assumed this role as part of the family's adaptive process during a time of stress. It was important to recognize that changing his role will imply some loss of power.

2. To encourage Monroe in finding other ways of having "adult male" status in the family besides disciplining younger siblings.

3. To assist the family with assimilating John as a member.

4. To assist John in understanding the values and culture into which he is trying to fit.

5. To give John information about effective parenting.

The characteristics of mountain families were considered when devising intervention strategy. Techniques that require little talking and more action were first attempted. For example:

1. John was to ask Monroe on a fishing or hiking trip. In this way, Monroe can share with John his knowledge of the land.

2. Monroe was asked to hunt and fish for the family and to cut and stack wood.

3. John was to ask Beulah for some of her child-raising opinions. As a means of helping John better understand some of the family's "ways," John and Beulah were to raise a garden together.

4. John was to read about Appalachian culture and to encourage Betty to tell him tales about her family history.

5. Betty and John were to take the STEP program together.

Working with Appalachian families offers a great challenge for the worker to be creative in his/her counseling approach. An awareness of the cultural differences and a willingness to be integrated into the community as an individual can contribute to better acceptance by the folks in the mountain area. Family therapy, especially outreach family therapy, is a viable means of intervention. However, it can only be effectively implemented when the worker meets the Appalachian person on his own ground.

FOOTNOTES

1. Weller, Jack E., Yesterday's People, Lexington: University of Kentucky Press, 1965, pp. 29, 30.

2. Ibid., pp. 33, 34.

3. Ibid., p. 35.

4. Ford, Thomas R., "The Passing of Provincialism," The Southern Appalachian Region: A Survey, Lexington: University of Kentucky Press, 1962, p. 20.

5. Weatherford, W.D., and Brewer, D.C., Life and Religion in Southern Appalachia: An Interpretation of Selected Data from the Southern Appalachian Studies, New York: Friendship Press, 1962, p. 10.

6. Weller, pp. 60-63.